Humana Employee Enrollment Form - 10-99 Employees FLORIDA

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in this application as "Humana".

PPO, EPO and Indemnity plans insured by Humana Health Insurance Company of Florida, Inc. POS and HMO plans offered by Humana Medical Plan, Inc.
Humana National POS plan insured by Humana Health Insurance Company of Florida, Inc. and offered by Humana Medical Plan, Inc.
Life plans insured or administered by Humana Insurance Company.
Prepaid, Basic, Intermediate and High Dental plans underwritten by The Dental Concern, Inc. Prepaid and AdvantagePlus Dental plans offered and administered by CompBenefits Company. All other Dental plans insured or administered by HumanaDental Insurance Company or Humana Insurance Company.
Vision plans insured or administered by Humana Insurance Company, CompBenefits Insurance Company or CompBenefits Company.

Please print clearly and fill in each applicable circle. Proposed effective date: _ _ / _ _ / _ _ _ _

Company name	Company city	State

Enrollment Information

Relationship	Last name, First name MI	Height (ft / in)	Weight (lbs.)	Gender	Full-time student?	Date of birth	Disabled? If yes, indicate reason.
Employee		/		❍ F ❍ M	N/A	_ _ / _ _ / _ _ _ _	❍ N ❍ Y Reason:
Spouse		/		❍ F ❍ M	N/A	_ _ / _ _ / _ _ _ _	❍ N ❍ Y Reason:
Child		/		❍ F ❍ M	❍ N ❍ Y	_ _ / _ _ / _ _ _ _	❍ N ❍ Y Reason:
Child		/		❍ F ❍ M	❍ N ❍ Y	_ _ / _ _ / _ _ _ _	❍ N ❍ Y Reason:
Child		/		❍ F ❍ M	❍ N ❍ Y	_ _ / _ _ / _ _ _ _	❍ N ❍ Y Reason:
Other (specify):		/		❍ F ❍ M	❍ N ❍ Y	_ _ / _ _ / _ _ _ _	❍ N ❍ Y Reason:

For Medical plans only: Do you wish to extend coverage for your dependent adult child(ren) up to age 30? ❍ N ❍ Y

EMPLOYEE INFORMATION: **HOURS WORKED PER WEEK:** ❍ **RETIREE** **DATE OF FULL-TIME HIRE:** _ _ / _ _ / _ _ _ _

SSN #	Street address	APT / Suite / Box

City	State	Zip code	Phone # ( )

Language: ❍ English ❍ Spanish	Email address	Occupation

Medical

Group #: Benefit #: Class/Div:

Coverage type: ❍ Employee only ❍ Employee and spouse ❍ Employee and child(ren) ❍ Family ❍ NO COVERAGE (complete waiver)

Plan name

1. Prior medical coverage during the past 18 months (individual or other group coverage)? ❍ N ❍ Y

Prior medical insurance carrier name	Policy #	**Prior coverage type:** ❍ Employee only ❍ Employee and spouse ❍ Employee and child(ren) ❍ Family	Effective date _ _ / _ _ / _ _ _ _ Term date _ _ / _ _ / _ _ _ _

2. Other medical coverage in effect at the same time as this Humana coverage (individual or other group coverage)? ❍ N ❍ Y

Other Medical Insurance carrier name	Policy #	**Other coverage type:** ❍ Employee only ❍ Employee and spouse ❍ Employee and child(ren) ❍ Family	Effective date _ _ / _ _ / _ _ _ _ Term date _ _ / _ _ / _ _ _ _

3. Medicare coverage:

Employee coverage: ❍ N ❍ Y	Medicare ID	Effective date _ _ / _ _ / _ _ _ _	Term date _ _ / _ _ / _ _ _ _
Spouse coverage: ❍ N ❍ Y	Medicare ID	Effective date _ _ / _ _ / _ _ _ _	Term date _ _ / _ _ / _ _ _ _

Health Savings Account

Group #: Benefit #: Class/Div:

If you have medical coverage under another plan, you may not be eligible for an HSA. Please check with your tax advisor for details.

Please refer to Humana's HSA contribution worksheet to calculate your maximum allowed contribution. You can find additional information on HSAs on Humana.com. Select the Quick Link for Spending Account information on the Member page.

Do you elect the Health Savings Account? ❍ N ❍ Y (If no, complete waiver.)	Beneficiary for this account will be the employee's estate. You may change beneficiary information on file with the bank that administers the HSA once the account is established.

Last name:	First name:

Dental Group #: | Benefit #: | Class/Div:

Coverage type: ❍ Employee only ❍ Employee and spouse ❍ Employee and child(ren) ❍ Family ❍ NO COVERAGE (complete waiver)

Plan name

Prior dental coverage during the past 12 months (individual or other group coverage)? ❍ N ❍ Y

Prior dental insurance carrier name	**Prior coverage type:** ❍ Employee only ❍ Employee and spouse ❍ Employee and child(ren) ❍ Family	Effective date _ _ / _ _ / _ _ _ _	Policy #
Prior orthodontia coverage in the past 12 months? ❍ N ❍ Y		Term date _ _ / _ _ / _ _ _ _	Prior carrier phone # ( )

Basic Life Group #: | Benefit #: | Class/Div:

Primary beneficiary name (Last, First MI)	Secondary beneficiary name (Last, First MI)	
Class (employer will provide you with this information if needed)	Annual salary (if applicable) $	**Basic dependent life?** ❍ N ❍ Y If no, complete waiver section.

Voluntary Life Group #: | Benefit #: | Class/Div:

Voluntary employee life coverage? ❍ N ❍ Y	Amount (min $15,000) $	Primary beneficiary name (Last, First MI)	Secondary beneficiary name (Last, First MI)
Voluntary spouse life coverage? ❍ N ❍ Y	Amount (min. $5,000) $	**Voluntary child(ren) life coverage?** ❍ N ❍ Y	Annual employee salary (if applicable) $

Vision Group #: | Benefit #: | Class/Div:

Coverage type: ❍ Employee only ❍ Employee and spouse ❍ Employee and child(ren) ❍ Family ❍ NO COVERAGE (complete waiver)

Plan name

Medical Health History (Complete for groups domiciled in Broward, Dade, Martin and Palm Beach Counties for eligible group size 51-99.)

This information should not be submitted more than 60 days prior to the effective date.

1. Within the past 24 months have you or any dependent to be covered been diagnosed or treated by a licensed medical provider for an illness or injury, had surgery or hospitalization recommended, or are currently pregnant? ❍ N ❍ Y	**2.** Within the past 24 months have you or any dependent to be covered been prescribed medication by a licensed medical provider? ❍ N ❍ Y	**3.** Have you or any dependent to be covered incurred medical expenses in excess of $7,500 in the past 12 months? ❍ N ❍ Y

If you answered "yes" to any of the questions above, please provide details below and specify the question number. Attach additional signed and dated sheets if necessary.

Question # & letter	Person treated (Last name, First name)
Condition	Treatments received
Medications prescribed	Current or future treatments or medications
Date diagnosed _ _ / _ _ / _ _ _ _	Date last seen by a doctor _ _ / _ _ / _ _ _ _

Waiver (refusal of coverage)

I hereby waive coverage for (check all that apply):

Medical for: ❍ Myself ❍ My spouse ❍ My dependent child(ren)
Dental for: ❍ Myself ❍ My spouse ❍ My dependent child(ren)
Basic Life for: ❍ Myself ❍ My spouse ❍ My dependent child(ren)
Vision for: ❍ Myself ❍ My spouse ❍ My dependent child(ren)
Health Savings Account for: ❍ Myself

I decline to apply for group coverage because of:

❍ Spousal coverage
❍ Medicare supplement
❍ Individual coverage
❍ Coverage under another carrier's plan provided by my employer
❍ Other:

Last name:	First name:

Agreement

True and complete acknowledgement

I understand, agree and represent:

- I have read this document or it has been read to me and answers provided are true and complete to the best of my knowledge and belief.
- Neither my employer nor the agent can waive any question, determine coverage or insurability, alter any contract or waive any of Humana's other rights and requirements.
- If this application for coverage is accepted, coverage will be effective on the date specified by Humana on the certificate of coverage/certificate of insurance. If I have a new dependent as a result of a qualifying event, I may in the future be able to enroll myself or my dependents provided I request enrollment within 31 days after the qualifying event.
- In the event that I should decide to apply for coverage hereafter, that subsequent application shall be subject to the applicable terms and conditions of the master group contract(s) or plan provisions which may require additional limitations and waiting periods.
- If I am declining coverage for myself or my dependents (including my spouse) because of other coverage, I may in the future be able to enroll myself or my dependents provided that I request enrollment within 31 days after my other coverage ends.
- If any deductions are required for this coverage, I authorize those deductions from my earnings. If selecting the Health Savings Account (HSA), I authorize Humana or its banking partners to provide my account number to my employer for the purposes of depositing any contributions.
- Any misrepresentation contained herein relied on by Humana may be used to reduce or deny a claims or void the contract within the contestable period if such misrepresentation materially affected the acceptance of the risk.

This document, together with any supplements, will form part of any contract and be the basis for any certificate of coverage/certificate of insurance issued.

Signature - please sign below if enrolling or waiving group coverage.

If you decide not to sign this authorization, Humana cannot complete your plan enrollment or determine your premium rate due to the inability to obtain the necessary information.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Employee or legal representative signature: _____ Date: _____

Name and relationship of legal representative: _____

Spouse signature: _____ Date: _____

(Only if selecting Life coverage over the guarantee issue amount.)