Humana Employee Enrollment Application — CALIFORNIA

Dental & Life

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

Dental HMO plans underwritten by Golden West Dental and Vision. All other Dental plans insured or administered by HumanaDental Insurance Company or Humana Insurance Company. Life plans insured or administered by Humana Insurance Company.

Please print clearly and fill in each applicable circle.

Dental Group number | Benefit number | Class/Division

Company name | Proposed Effective Date (MMDDYYYY)

Company city | State

Employee Information

CA-80124-GN 6/2006

Last name | First name | MI | Date of birth

Social Security number | Phone number

Gender: ❍ Female ❍ Male | Email address

Street address | Apt / Suite / PO Box number

City | State | Zip code | County

Language of choice: ❍ English ❍ Spanish

Employment status: ❍ Full-time employee: Number of hours worked per week | Date of full-time hire | ❍ Retiree

Are you disabled or unable to perform normal activities? ❍ No ❍ Yes If yes, indicate reason:

Dependent Information

CA-80124-DP 6/2006

Please enter information for each dependent, including spouse, applying for coverage. For additional dependents, copy and attach an additional Dependent Information form.

1. Last name | First name | MI | Date of birth

Social Security number | Gender: ❍ Female ❍ Male | Relationship: ❍ Spouse ❍ Child ❍ Other:

Dependent status (if applicable): ❍ Full-time student ❍ Disabled | If disabled, indicate reason:

DHMO: Network name

DHMO: Primary dentist | Facility number | Current Patient: ❍ No ❍ Yes

2. Last name | First name | MI | Date of birth

Social Security number | Gender: ❍ Female ❍ Male | Relationship: ❍ Spouse ❍ Child ❍ Other:

Dependent status (if applicable): ❍ Full-time student ❍ Disabled | If disabled, indicate reason:

DHMO: Network name

DHMO: Primary dentist | Facility number | Current Patient: ❍ No ❍ Yes

3. Last name | First name | MI | Date of birth

Social Security number | Gender: ❍ Female ❍ Male | Relationship: ❍ Spouse ❍ Child ❍ Other:

Dependent status (if applicable): ❍ Full-time student ❍ Disabled | If disabled, indicate reason:

DHMO: Network name

DHMO: Primary dentist | Facility number | Current Patient: ❍ No ❍ Yes

4. Last name | First name | MI | Date of birth

Social Security number | Gender: ❍ Female ❍ Male | Relationship: ❍ Spouse ❍ Child ❍ Other:

Dependent status (if applicable): ❍ Full-time student ❍ Disabled | If disabled, indicate reason:

DHMO: Network name

DHMO: Primary dentist | Facility number | Current Patient: ❍ No ❍ Yes

Group Number | Social Security Number

Dental

CA-80124-HD 6/2006

Coverage type: ❍ Employee only ❍ Employee and spouse ❍ Employee and child(ren) ❍ Family ❍ Other

Plan name

DHMO: Network name

DHMO: Primary dentist | Facility number | Current Patient: ❍ No ❍ Yes

Within the past 12 months, have you had any individual or other group dental coverage? ❍ No ❍ Yes Orthodontia coverage? ❍ No ❍ Yes

Effective date | Term date

Prior coverage type: ❍ Employee only ❍ Employee and spouse ❍ Employee and child(ren) ❍ Family

Basic Life

CA-80124-HL 6/2006

Group number | Benefit number | Class/Division

Primary beneficiary name | Secondary beneficiary name

Class (employer will provide you with this information if needed) | Annual salary (if applicable) $

Basic dependent life: ❍ No ❍ Yes If no, complete waiver section.

Voluntary Life

Group number | Benefit number | Class/Division

Do you elect voluntary employee life coverage? ❍ No ❍ Yes Amount (minimum of $15,000) $ | Annual salary $

Primary beneficiary name | Secondary beneficiary name

Voluntary dependent life: (available only if employee elects voluntary life coverage) Do you elect voluntary child(ren) life coverage? ❍ No ❍ Yes

Do you elect voluntary spouse life coverage? ❍ No ❍ Yes Amount (minimum of $5,000) $

Waiver (Refusal of coverage)

CA-80124-WV 6/2006

I acknowledge that I have been given the opportunity to apply for group coverage available to me and my dependents through my employer. I proclaim that I was not pressured or forced by my employer, the writing agent, or Humana into waiving (declining) coverage. If I have waived any coverage offered to me or my dependents, my signature below is evidence of this action. I hereby waive coverage for (check all that apply):

Dental for: ❍ Myself ❍ My spouse ❍ My dependent child(ren)

Basic life for: ❍ Myself ❍ My spouse ❍ My dependent child(ren)

I decline to apply for group coverage because of (check all that apply): ❍ Spousal coverage ❍ Medicare supplement ❍ Individual coverage ❍ Coverage under another carrier's plan provided by my employer ❍ Other:

I understand and agree:

- In the event that I should decide to apply for such coverage hereafter, that such subsequent application shall be subject to the applicable terms and conditions of the master group contract(s) or plan provisions as described in the Summary Plan Description which may require additional limitations and waiting periods.
- I may be required to furnish, at my own expense, evidence of health status satisfactory to Humana.
- 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 I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents provided that I request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.
- Humana reserves the right to delay medical coverage and/or deny life or dental coverage with any future application for coverage.

Group Number	Social Security Number

Agreement

CA-80124-AA 6/2006

True and complete acknowledgement

I understand, agree and represent:

- I have read this document or it has been read to me.
- The answers provided within this entire application for coverage are to the best of my knowledge and belief, true and complete.
- Neither my employer nor the agent has the authority to waive a complete answer to 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.
- Any misrepresentation contained herein relied on by Humana may be used to reduce or deny a claim or void the contract within the contestable period if such misrepresentation materially affected the acceptance of the risk.
- Medical and life domestic partner coverage eligibility is subject to my domestic partner and I being of the same sex or the opposite sex if either of us are over age 62.

I hereby enroll for benefits for which I am presently eligible or for which I may become eligible under my employer's group contract(s). If any deductions are required for this coverage, I authorize such deductions from my earnings. I reserve the right to revoke this deduction authorization at any time upon written notice unless I have chosen to use pretax deductions.

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.

Authorization

My dependents and I authorize any physician, medical or health care practitioner, hospital, clinic, veterans administration facility, other medical or medically-related facility, third party administrator, Pharmacy Benefit Manager, insurance, HMO or reinsuring company, the Medical Information Bureau, Inc., employer, the Consumer Reporting Agency or banking and financial institutions having information regarding myself and my dependents, including information concerning, advice, diagnosis, treatment and care of the physical, psychiatric, mental or emotional conditions, drug, substance or alcohol abuse, illness, and copies of all hospital or medical records, non-public personal health information, and any other non-medical information to share any and all such information with Humana, its reinsurer or its legal representatives, and its affiliates.

My dependents and I understand and agree:

- The information obtained by use of this authorization may be used by Humana to determine eligibility for coverage, eligibility for benefits under an existing policy, plan administration, and make claim determinations.
- If you decide not to sign this authorization, Humana can not complete your plan enrollment or determine your premium rate due to the inability to obtain the necessary information.
- Any information obtained will not be released by Humana to any person or organization except to reinsuring companies, the Medical Information Bureau, Inc. or insurance support organizations performing health care operations or business or legal services in connection with an application, claim or as may be otherwise lawfully required, or as I (we) may further authorize.
- Once personal and health (including medical, dental and pharmacy) information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal and state privacy requirements.
- A copy of this authorization is available to me or my legal representative upon written request.
- A photographic copy of this authorization shall be as valid as the original.
- This authorization shall be valid for two years from the date shown below.
- I have the right to revoke this authorization at any time:
  - To revoke this authorization, I must do so in writing and send my written revocation to Humana's Privacy Office.
  - The revocation will not apply to information that has already been released in response to this authorization.
  - The revocation will become effective after it is received by Humana's Privacy Office.

CALIFORNIA PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH INSURANCE COMPANIES AS A CONDITION OF OBTAINING HEALTH INSURANCE COVERAGE.

Signature - please sign below if enrolling or waiving group coverage

Employee or legal representative signature: _____ Date: _____

Name and relationship of legal representative: _____