Large Group Employee and Individual Application and Enrollment Form

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in the Large Group Employee and Individual Application and Enrollment Form as "Humana".

HMO plans offered by **Humana Health Plan, Inc**. PPO, Classic medical and Life plans insured or administered by **Humana Insurance Company**. Dental PPO, Preventative Plus and Traditional Preferred plans insured or administered by **HumanaDental Insurance Company**. Dental prepaid plans and AdvantagePlus dental plans offered and administered by **CompBenefits Dental, Inc**. Vision plans insured or administered by **Humana Insurance Company** or **HumanaDental Insurance Company** or **CompBenefits Insurance Company**. Short Term Disability, Long Term Disability, Life and Workplace Voluntary plans insured or administered by **Kanawha Insurance Company**.

Print clearly and completely fill in each applicable circle.

Employer / Group name

Employer / Group city

State

Qualifying Event Instructions **Office use only**

❍ New business enrollment ❍ Open Enrollment event ❍ Marital status change ❍ Other_____

❍ New hire/Newly eligible ❍ Rehire/Reinstatement Qualifying event date (MM/DD/YYYY) Benefit effective date (MM/DD/YYYY)

❍ Dependent birth or adoption ❍ Loss of coverage / / / / /

Employee / Individual information

Last name

First name

MI

Social security number - -

Date of birth (MM/DD/YYYY) / /

Area code ( )

Phone number -

Street address

Apt / Suite / PO box number

Gender ❍ Female ❍ Male

Language of choice ❍ English ❍ Spanish

City

State

Zip code

County / Parish

E-mail address

Employment status ❍ Full-time employee / individual ❍ Retiree ❍ COBRA Date of full-time hire (MM/DD/YYYY) / /

Do you have a disability that affects your ability to communicate or read? ❍ No ❍ Yes

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

Annual Salary

$

Hours Worked per Week

Occupation

HMO/POSonly Primary care physician name

Primary care physician ID #

Current patient? ❍ Yes ❍ No

HMO/POSonly OBGYN Primary care physician name (if applicable)

Primary care physician ID #

Current patient? ❍ Yes ❍ No

Last name: First name:

Dependent information

Enter information for each covered dependent, including spouse.

1

Dependent last name | First name | MI | Gender ❍ Female ❍ Male

Social security number - - | Date of birth (MM/DD/YYYY) / / | Relationship ❍ Spouse ❍ Child ❍ Other:_____

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

Not applicable for HumanaAccess HMO

HMO/POS only — Primary care physician name | Primary care physician ID # | Current patient? ❍ Yes ❍ No

HMO/POS only — OBGYN Primary care physician name (if applicable) | Primary care physician ID # | Current patient? ❍ Yes ❍ No

2

Dependent last name | First name | MI | Gender ❍ Female ❍ Male

Social security number - - | Date of birth (MM/DD/YYYY) / / | Relationship ❍ Spouse ❍ Child ❍ Other:_____

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

Not applicable for HumanaAccess HMO

HMO/POS only — Primary care physician name | Primary care physician ID # | Current patient? ❍ Yes ❍ No

HMO/POS only — OBGYN Primary care physician name (if applicable) | Primary care physician ID # | Current patient? ❍ Yes ❍ No

3

Dependent last name | First name | MI | Gender ❍ Female ❍ Male

Social security number - - | Date of birth (MM/DD/YYYY) / / | Relationship ❍ Spouse ❍ Child ❍ Other:_____

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

Not applicable for HumanaAccess HMO

HMO/POS only — Primary care physician name | Primary care physician ID # | Current patient? ❍ Yes ❍ No

HMO/POS only — OBGYN Primary care physician name (if applicable) | Primary care physician ID # | Current patient? ❍ Yes ❍ No

4

Dependent last name | First name | MI | Gender ❍ Female ❍ Male

Social security number - - | Date of birth (MM/DD/YYYY) / / | Relationship ❍ Spouse ❍ Child ❍ Other:_____

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

Not applicable for HumanaAccess HMO

HMO/POS only — Primary care physician name | Primary care physician ID # | Current patient? ❍ Yes ❍ No

HMO/POS only — OBGYN Primary care physician name (if applicable) | Primary care physician ID # | Current patient? ❍ Yes ❍ No

Last name: | First name:

Use the following alternate address for these dependents: ❍ 1 ❍ 2 ❍ 3 ❍ 4

Street address

Apt / Suite / PO box number

City | State | Zip code | County

Medical

Coverage type: ❍ Employee / Individual only
❍ Employee / Individual & spouse
❍ Employee / Individual & child(ren)
❍ Family
❍ Other

Office use only
Group # | Benefit # | Class/Div #

Plan name | Network name

- Do you or any covered dependent(s) currently have other medical coverage, such as a spouse's plan, another Humana medical plan, or Medicare? ❍ Yes ❍ No If yes, list all: (This section must be completed for Humana to process any medical claims.)

Medicare ID or medical carrier name:
Starting date (MM/DD/YYYY) / /
End date, if applicable (MM/DD/YYYY) / /
Coverage Type (check all that apply)
❍ Employee / Individual
❍ Spouse
❍ Child(ren)

Medicare ID or medical carrier name:
Starting date (MM/DD/YYYY) / /
End date, if applicable (MM/DD/YYYY) / /
Coverage Type (check all that apply)
❍ Employee / Individual
❍ Spouse
❍ Child(ren)

- Have you or any covered dependent(s) had medical insurance from a company (including another Humana plan) in the past 1-18 months? ❍ Yes ❍ No If yes, list all: (This section must be completed for Humana to process any medical claims)

Prior medical carrier name:
Starting date (MM/DD/YYYY) / /
End date, if applicable (MM/DD/YYYY) / /
Coverage Type (check all that apply)
❍ Employee / Individual
❍ Spouse
❍ Child(ren)

Prior medical carrier name:
Starting date (MM/DD/YYYY) / /
End date, if applicable (MM/DD/YYYY) / /
Coverage Type (check all that apply)
❍ Employee / Individual
❍ Spouse
❍ Child(ren)

Health Savings Account (HSA) Applicable only with High Deductible Health Plan selection

Do you elect the Health Savings Account?
❍ Yes ❍ No If no, complete waiver section

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

Office use only
Group # | Benefit # | Class/Div #

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.

Beneficiary for this account will be the employee / individual '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:

Flexible Spending Account (FSA)

Do you elect the flexible health account?
❍ Yes ❍ No If no, complete waiver section

Annual amount elected:
$, .00

Office use only
Group # Benefit # Class/Div #
FSA HC

Start date (MM/DD/YYYY) / / End date (MM/DD/YYYY) / /

Do you elect the flexible dependent care account?
❍ Yes ❍ No If no, complete waiver section

Annual amount elected:
$, .00

Office use only
Group # Benefit # Class/Div #
FSA DC

Start date (MM/DD/YYYY) / / End date (MM/DD/YYYY) / /

Dental

Office use only Group # Benefit # Class/Div #

Coverage Type ❍ Employee / Individual only ❍ Employee / Individual and spouse ❍ Employee / Individual and child(ren) ❍ Family ❍ Other

Plan name

- Within the past 12 months, have you or any covered family individual had any dental or orthodontia coverage, such as a spouse's dental coverage? ❍ Yes ❍ No If yes, list all: (This section must be completed for Humana to process any dental claims)

Current dental carrier name: Orthodontia coverage? ❍ Yes ❍ No Starting date (MM/DD/YYYY) / / End date, if applicable (MM/DD/YYYY) / /

Coverage Type (check all that apply) ❍ Employee / Individual ❍ Spouse ❍ Child(ren)

Prior dental carrier name: Orthodontia coverage? ❍ Yes ❍ No Starting date (MM/DD/YYYY) / / End date, if applicable (MM/DD/YYYY) / /

Coverage Type (check all that apply) ❍ Employee / Individual only ❍ Employee / Individual and spouse ❍ Employee / Individual and child(ren) ❍ Family

HMO/POS only — Employee Primary care dentist name — Dentist ID # — Current patient? ❍ Yes ❍ No

		Employee Primary care dentist name	Dentist ID #	Current patient?
1	DHMO:			❍ Yes ❍ No
2	DHMO:			❍ Yes ❍ No
3	DHMO:			❍ Yes ❍ No

Basic Life / AD&D

Office use only Group # Benefit # Class/Div #

Do you elect basic employee / individual life coverage? ❍ Yes ❍ No If no, complete waiver section

Class (employer / group will provide you with this information if needed)

Do you elect basic dependent life? ❍ Yes ❍ No If no, complete waiver section

Last name: | First name:

Voluntary Life / AD&D

Office use only Group # | Benefit # | Class/Div #

Do you elect voluntary employee / individual life coverage?

❍ Yes ❍ No If no, complete waiver section

If yes, amount elected (minimum of $15,000): $, .00

Voluntary dependent life selection (available only if employee / individual elects voluntary life coverage):

Do you elect voluntary spouse life coverage? ❍ Yes ❍ No If no, complete waiver section

If yes, voluntary spouse life coverage (minimum of $5,000): $, .00

Do you elect voluntary child(ren) life coverage? ❍ Yes ❍ No If no, complete waiver section

Vision

Office use only Group # | Benefit # | Class/Div #

Covered individual ❍ Employee / Individual only ❍ Employee / Individual and spouse ❍ Employee / Individual and child(ren) ❍ Family ❍ Other

Plan name

Short Term Disability

Do you elect short term disability coverage?

❍ Yes ❍ No If no, complete waiver section

Buy-up percent/amount _____

Office use only

Group # | Benefit # | Class # | Div #

Long Term Disability

Do you elect long term disability coverage?

❍ Yes ❍ No If no, complete waiver section

Buy-up percent/amount _____

Office use only

Group # | Benefit # | Class # | Div #

Group Term Life / AD&D

Office use only Group # | Benefit # | Class # | Div #

Coverage requested for (check all that apply)		Coverage requested (complete only if plan provides a choice of benefit schedules)	Cost per pay period
Employee / Individual	❍ Basic Term Life	_____	$, .00
	❍ Supplemental Term Life*	_____	$, .00
	❍ Basic AD&D	_____	$, .00
	❍ Supplemental AD&D	_____	$, .00
Spouse	❍ Basic Term Life	_____	$, .00
	❍ Supplemental Term Life*	_____	$, .00
	❍ Basic AD&D	_____	$, .00
	❍ Supplemental AD&D	_____	$, .00
Child(ren)	❍ Basic Term Life	_____	$, .00
	❍ Supplemental Term Life*	_____	$, .00
	❍ Basic AD&D	_____	$, .00
	❍ Supplemental AD&D	_____	$, .00

*Complete Evidence of Insurability form if selecting one of these benefit amounts.

Last name: | First name:

Workplace Voluntary Benefits: Optional riders availability based on employer / group election.

Accident

Office use only Group # | Benefit # | Class # | Div #

❍ Accident ❍ N ❍ Y **Benefit Level:** ❍ 1 ❍ 2 ❍ 3 ❍ 4

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

❍ Optional Hospital Intensive Care Unit Benefits Rider ❍ $150 ❍ $300 ❍ $450 ❍ $600
❍ Optional Fracture and Dislocation Benefits Rider ❍ $750 ❍ $1,500
❍ Optional Accident Total Disability Benefits Rider: Elimination Period ❍ 1 Day ❍ 7 Days ❍ 14 Days ❍ 30 Days
Elimination Benefit ❍ $400 ❍ $500 ❍ $600 ❍ $700 ❍ $800 ❍ $900 ❍ $1000

Accident - 2012

Office use only Group # | Benefit # | Class # | Div #

❍ Accident ❍ N ❍ Y **Benefit Level:** ❍ 1 ❍ 2 ❍ 3 ❍ 4

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

Disability Income Plus

Office use only Group # | Benefit # | Class # | Div #

❍ Disability Income Covering Accident and Sickness ❍ N ❍ Y
Base Benefit Period: ❍ 3 Month ❍ 6 Month ❍ 1 Year ❍ 2 Year ❍ 3 Year
Base Elimination Period: ❍ 0/7 ❍ 7/7 ❍ 0/14 ❍ 14/14 ❍ 30/30 ❍ 60/60 ❍ 90/90 ❍ 180/180 ❍ 365/365

❍ Disability Income Covering Accident and Sickness with Waiver of Elimination Period ❍ N ❍ Y
Base Benefit Period: ❍ 3 Month ❍ 6 Month ❍ 1 Year ❍ 2 Year ❍ 3 Year
Base Elimination Period: ❍ 0/7 ❍ 7/7 ❍ 0/14 ❍ 14/14
Monthly Benefit $ ___ , ___ .00
Optional Disability Income Benefits: ❍ ICU/CCU Benefit ❍ $200 ❍ $400 ❍ $600 ❍ $800
❍ Physical Therapy Benefit
❍ COBRA Rider
COBRA Monthly Benefit $ ___ , ___ .00

Disability Income Advantage

Office use only Group # | Benefit # | Class # | Div #

❍ Disability Income Advantage ❍ N ❍ Y
Base Benefit Period: ❍ 3 Month ❍ 6 Month ❍ 1 Year ❍ 2 Year ❍ 3 Year
Base Elimination Period: ❍ 0/7 ❍ 7/7 ❍ 0/14 ❍ 14/14 ❍ 30/30 ❍ 60/60 ❍ 90/90 ❍ 180/180 ❍ 365/365
Optional Riders: ❍ Hospital Confinement ❍ COBRA Rider
Monthly Benefit $ ___ , ___ .00
COBRA Monthly Benefit $ ___ , ___ .00

Whole Life / AD&D

Office use only Group # | Benefit # | Class # | Div #

❍ Whole Life / AD&D ❍ N ❍ Y ❍ Whole Life 99 ❍ Whole Life 65
❍ AD&D Rider ❍ Automatic Premium Loan Option
Employee / Individual Benefit $ ___ , ___ .00
❍ Automatic Benefit Increase Rider ❍ $1 / Week ❍ $2 / Week
❍ Employee Term Rider to 65 Employee / Individual Benefit $_____
❍ Family Term Rider Spouse Benefit $ _____ Child(ren) Benefit $ _____

Last name: | First name:

Whole Life Spouse / AD&D

Office use only Group # | Benefit # | Class # | Div #

❍ Whole Life Spouse / AD&D ❍ N ❍ Y ❍ Whole Life 99 ❍ Whole Life 65

Spouse Benefit

❍ AD&D Rider ❍ Automatic Premium Loan Option

$ ___,___.00

❍ Family Term Rider (Child Coverage Only) Child(ren) Benefit Amount $_____

Whole Life Child(ren) / AD&D

Office use only Group # | Benefit # | Class # | Div #

❍ Whole Life Child(ren) / AD&D ❍ N ❍ Y

Child(ren) listed here must also be included as dependents under the Enrollment Information section of this application.

❍ N ❍ Y **Coverage on Child 1** Child 1 Name_____ Child 1 Benefit $ _____

❍ N ❍ Y **Coverage on Child 2** Child 2 Name_____ Child 2 Benefit $ _____

❍ N ❍ Y **Coverage on Child 3** Child 3 Name_____ Child 3 Benefit $ _____

Level Term Life

Office use only Group # | Benefit # | Class # | Div #

❍ Level Term Life ❍ N ❍ Y **Coverage type:** ❍ Employee / Individual only ❍ Spouse ❍ Child(ren) ❍ No Coverage

Base Plan: ❍ 10 Year Term ❍ 20 Year Term

Optional Benefit: ❍ Automatic Benefit Increase

Employee / Individual Benefit | Spouse Benefit | Child(ren) Benefit

$ ___,___.00 $ ___,___.00 $ ___,___.00

If your employer or group has elected the critical illness rider, have you or any dependent had a parent, brother, or sister with a history of heart attack, heart disease, stroke, or cancer diagnosis prior to age 60? ❍ N ❍ Y

If yes, please indicate whether this applies to you (employee / individual), your spouse or a dependent.

❍ You (employee / individual) ❍ Spouse ❍ Dependent Name_____

Critical Illness Expense

Office use only Group # | Benefit # | Class # | Div #

❍ Critical Illness ❍ N ❍ Y

❍ Critical Illness and Cancer ❍ N ❍ Y

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

Optional Benefits: ❍ Automatic Benefit Increase ❍ Health Screening

Employee / Individual Benefit

$ ___,___.00

Have you or any dependent had a parent, brother, or sister with a history of heart attack, heart disease, stroke, or cancer diagnosis prior to age 60? ❍ N ❍ Y If yes, please indicate whether this applies to you (employee / individual), your spouse or a dependent. ❍ You (employee / individual) ❍ Spouse ❍ Dependent Name_____

Group Lump Sum Cancer

Office use only Group # | Benefit # | Class # | Div #

❍ Group Lump Sum Cancer ❍ N ❍ Y **Coverage type:** ❍ Employee / Individual only ❍ Employee / Individual and spouse ❍ Employee / Individual and child(ren) ❍ Family

Does anyone on this application have a parent, brother, or sister with a history of cancer diagnosis prior to age 60? ❍ N ❍ Y

If yes, please indicate whether this applies to you (employee / individual), your spouse or a dependent.

❍ You (employee / individual) ❍ Spouse ❍ Dependent Name_____

Rider: ❍ Automatic Benefit Increase ❍ Health Screenings

Benefit

$ ___,___.00

Last name: | First name:

Cancer Expense

Office use only Group # | Benefit # | Class # | Div #

❍ Cancer Expense ❍ N ❍ Y **Coverage type:** ❍ Employee / Individual only ❍ Employee / Individual and spouse ❍ Employee / Individual and child(ren) ❍ Family

Base Benefit
$, .00

❍ Lump Sum Benefit (Equal to 50% of Base Benefit Amount) **Rider:** ❍ Hospital Indemnity Base Benefit Rider

Supplemental Health

Office use only Group # | Benefit # | Class # | Div #

❍ Supplemental Health ❍ N ❍ Y **Coverage type:** ❍ Employee / Individual only ❍ Employee / Individual and spouse ❍ Employee / Individual and child(ren) ❍ Family

Plan type: ❍ 1 ❍ 2 ❍ 3 ❍ 4

Beneficiary Information for Life, Disability and Workplace Voluntary Benefits

Primary beneficiary
Last name | First name | MI

Relationship to employee / individual

Secondary beneficiary
Last name | First name | MI

Relationship to employee / individual

Last name: | First name:

Evidence of Health Status - Do not submit more than 90 days prior to the effective date

Complete this section if you are selecting workplace voluntary (excludes Accident) and/or medical benefits.

1a. In the past 12 months has any applicant used any tobacco product? If yes, applies to: ❍ N ❍ Y

❍ You (employee) ❍ Dependent 1

❍ Dependent 2

❍ Dependent 3

❍ Dependent 4

1b. Is any applicant currently a smoker? If yes, applies to: ❍ N ❍ Y

❍ You (employee) ❍ Dependent 1

❍ Dependent 2

❍ Dependent 3

❍ Dependent 4

2. In the past 12 months, have you missed 5 or more consecutive days of work due to an injury or illness other than as a result of a cold, the flu, back problems, strained/sprained/fractured/broken limb or as a result of pregnancy? ❍ N ❍ Y

3. Has anyone on this application been treated or diagnosed by a doctor or member of the medical profession for an immune system disorder (i.e. Lupus, ITP), AIDS or an AIDS-related complex? ❍ N ❍ Y

4. Within the past 5 years, has anyone on this application been diagnosed with diseases or disorders related to, counseled, consulted, or treated by a doctor, including surgery, for any of the following:

a.	Coronary artery disease, chest pain, heart surgery, or any disease of the arteries, or blood disorders; anemia; hemophilia; phlebitis; high blood pressure (reading higher than 140/90)?	❍ N ❍ Y	**g.**	Diabetes; liver or thyroid disease; hepatitis; cirrhosis; or enlargement of the lymph nodes?	❍ N ❍ Y
b.	Nervous, mental or emotional disorder; convulsions; epilepsy; unconsciousness; Multiple Sclerosis; Parkinson's Disease; Cerebral Palsy?	❍ N ❍ Y	**h.**	Rheumatoid arthritis; or back disorders; or joint disorders?	❍ N ❍ Y
c.	Stroke; Transient Ischemic Attack (TIA)?	❍ N ❍ Y	**i.**	Paralysis, or any other physical impairment or deformity?	❍ N ❍ Y
d.	Emphysema; asthma, or other disease of lungs, or respiratory organs?	❍ N ❍ Y	**j.**	Chronic Fatigue Syndrome/Fibromyalgia?	❍ N ❍ Y
e.	End stage renal disease; disease of kidney?	❍ N ❍ Y	**k.**	Diseases of the eye, ear, nose, or throat? Disease or disorder which has led or may lead to a permanent or progressive loss of vision, hearing or speech?	❍ N ❍ Y
f.	Cancer, and/or cancerous tumor; including skin cancer?	❍ N ❍ Y	**l.**	Alcoholism or drug habit?	❍ N ❍ Y

Last name: | First name:

Evidence of Health Status (continued)

5.	Has anyone on this application been advised by a member of the medical profession to have any diagnostic test, hospitalization, or surgery that has not been completed within the past 5 years?	❍ N ❍ Y

	First Name	MI	Height (ft/in)	Weight (lbs)
❍ Employee last name			'	
❍ Dependent 1 last name			'	
❍ Dependent 2 last name			'	
❍ Dependent 3 last name			'	
❍ Dependent 4 last name			'	

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 (reorder IL-51340-MH), if necessary.

Question# | Person Treated Last name | First Name

Condition | Treatments recieved

Medications | Current or future treatments or medications

Date diagnosed (MM/DD/YYYY) | Date last seen by a doctor (MM/DD/YYYY)

Last name: | First name:

Waiver (refusal of coverage)

I acknowledge that I have been given the opportunity to apply for group coverage available to me and my dependents through my employer / group. I proclaim that I was not pressured or forced by my employer / group, 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):

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)
Voluntary Life for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Vision for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Group Term Life for:	❍ Myself		
Short Term Disability for:	❍ Myself		
Long Term Disability for:	❍ Myself		
Health Savings Account for:	❍ Myself		
Flexible Health Account for:	❍ Myself		
Flexible Dependent Care Account for:	❍ Myself		

Waive Coverage for Workplace Voluntary Benefits:

Whole Life for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Level Term Life for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Critical Illness Expense for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Group Lump Sum Cancer for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Cancer Expense for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Supplemental Health for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Accident for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Disability Income Plus for:	❍ Myself		
Disability Income Advantage 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 / group
- ❍ Other:

_____

True and complete acknowledgement

I understand, agree, and represent:

- I have read the Large Group Employee and Individual Application and Enrollment Form 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 / group 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 the Large Group Employee and Individual Application and Enrollment Form for coverage is accepted, coverage will be effective on the date specified by Humana on the policy or 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.
- If I or my dependents become eligible for premium or rate subsidies under Medicaid or the Children's Health Insurance Program (CHIP), I may in the future be able to enroll myself or my dependents provided I request enrollment within 60 days after the qualifying event. I understand eligibility for enrollment does not apply to a High Deductible Health Plan (HDHP).
- In the event that I should decide to apply for coverage hereafter, that subsequent Large Group Employee and Individual Application and Enrollment Form shall be subject to the applicable terms and conditions of the master group contract(s), policy provisions or certificate provisions which may require additional limitations and waiting periods.
- Based on the coverage I have elected, I may be required to furnish 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 am declining coverage for myself or my dependents (including my spouse) because of coverage under Medicaid or CHIP, I may in the future be able to enroll myself or my dependents provided that I request enrollment within 60 days after my coverage under these programs ends. I understand eligibility for enrollment does not apply to an HDHP.
- Humana reserves the right to delay medical coverage and/or deny life or dental coverage with any future application for coverage.
- 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 / group for the purposes of depositing any contributions.
- If I am applying for coverage for my dependents (including my spouse) I attest by my signature below, I have gathered the necessary health information from my dependents in order to fully and truthfully complete the Large Group Employee and Individual Application and Enrollment Form.
- If I have selected workplace voluntary benefits, and if coverage is not issued as initially applied for, I hereby authorize Humana to decrease or increase the premium or rate amount stated on the Large Group Employee and Individual Application and Enrollment Form to cover the benefit actually issued.
- An act of fraud or an intentional misrepresentation of a material fact may void or terminate an individual's or group's coverage as specified under the terms of the Policy or Certificate. Providing incomplete, inaccurate, or untimely information may void, reduce, or increase past premium, or terminate an individual's coverage or the group's coverage.
- Rates or premium quoted and the effective date requested are not guaranteed. The final rate or premium and effective date will be determined upon underwriting review and approval of the Large Group Employee and Individual Application and Enrollment Form by Humana.
- Any person who willingly and knowingly submits this Large Group Employee and Individual Application and Enrollment Form containing a false, incomplete, or deceptive statement may be guilty of insurance fraud.

If you decide not to sign this agreement, we will decline to enroll you in an insurance product or to give you insurance benefits.

Last name: | First name:

Authorization

My dependents and I understand and agree:

- The information obtained by use of this authorization may be used by Humana to make claims determinations, determine eligibility for coverage, eligibility for benefits under an existing policy and plan administration.
- Any information obtained will not be released by Humana to any person or organization except to reinsuring companies, the Medical Information Bureau, Inc. or other persons or organizations performing health care operations or business or legal services in connection with this Large Group Employee and Individual Application and Enrollment Form, claim or as may be otherwise lawfully required, or as I (we) may further authorize.

Authorization for Release of Medical Records for Life or Disability

If my dependents or I have selected life or disability, I authorize any third party to have information regarding myself. This includes any medical or non-medical information and to share any and all such information with Humana, its reinsurer or its legal representatives, and its affiliates. Once personal and health (including medical, dental and pharmacy) information is disclosed pursuant to this authorization, the recipient may redisclose it and the information may not be protected by federal and state privacy requirements.

The Large Group Employee and Individual Application and Enrollment Form, together with any supplemental forms, will make up part of any contract and be the basis for any policy or certificate.

Signature - Please sign below if enrolling or waiving any group coverage

Employee / Individual or legal representative signature

Date ☐☐ / ☐☐ / ☐☐☐☐

Name and relationship of legal representative (if a covered dependent) _____

Agent / Producer Information

If applying for workplace voluntary benefits, this section to be completed by Agent or Producer.

1. Agent / Agency of Record:	**2. Agent / Agency of Record:**
Name (print)	Name (print)
Humana Agent #	Humana Agent #
Commission split:	Commission split:

1. Writing Agent / Producer:	**2. Writing Agent / Producer:**
Name (print)	Name (print)
Humana Agent #	Humana Agent #
Commission split:	Commission split:

Will the coverage selected replace or change any existing life or disability insurance policy(s) and/or annuity(s)? ❍ N ❍ Y

As the Writing Agent / Producer, I acknowledge that I am responsible to meet with the primary applicant submitting the Large Group Employee and Individual Application and Enrollment Form in order to fully and accurately represent the terms and conditions of the plans and services of the offering or insuring entity, or one of its subsidiaries. These provisions are available to me and the primary applicant in the benefit summary document or other plan literature.

Signed at _____ County _____ State

Writing Agent's Signature _____ Date __ __/__ __/__ __ __ __

The original version of this Agreement is in the English language. If there are any discrepancies or conflicts between the English and any other version that has been translated into another language, the English version will control.

Last name:	First name:

Additional Details to Medical Questions

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

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 _ _ / _ _ / _ _ _ _

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 _ _ / _ _ / _ _ _ _

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 _ _ / _ _ / _ _ _ _

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 _ _ / _ _ / _ _ _ _

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 _ _ / _ _ / _ _ _ _

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 _ _ / _ _ / _ _ _ _

Employee signature ____ Date _ _ / _ _ / _ _ _ _

Spouse signature (if covered dependent) ____ Date _ _ / _ _ / _ _ _ _

Child signature (if covered dependent over the legal age) ________________________________ Date_ _ / _ _ / _ _ _ _

Child signature (if covered dependent over the legal age) ________________________________ Date_ _ / _ _ / _ _ _ _

Child signature (if covered dependent over the legal age) ________________________________ Date_ _ / _ _ / _ _ _ _