

Humana Employee Enrollment Form - 20-99 Employees

GEORGIA

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in this application as "Humana". HMO and POS plans offered by Humana Employers Health Plan of Georgia, Inc., and/or insured or administered by Humana Insurance Company. PPO and Classic Medical plans, Life, and Vision plans insured or administered by Humana Insurance Company. Dental plans insured or administered by HumanaDental Insurance Company, Humana Insurance Company, CompBenefits Insurance Company or CompBenefits of Georgia, Inc. CompBenefits Vision plan insured and administered by CompBenefits Insurance Company.

Please print clearly and fill in each applicable circle.

Proposed effective date: ___/___/___

Company name	Company city	State
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Enrollment Information GA-72000-EI 3/2008

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

EMPLOYEE INFORMATION:	HOURS WORKED PER WEEK:	<input type="radio"/> RETIREE	DATE OF FULL-TIME HIRE: ___/___/___
SSN #	Street address	APT / Suite / Box	
City	State	Zip code	Phone # ()
Language: <input type="radio"/> English <input type="radio"/> Spanish		Email address	

Medical GA-72000-MD 3/2008

Group #:	Benefit #:	Class/Div:	
Coverage type: <input type="radio"/> Employee only <input type="radio"/> Employee and spouse <input type="radio"/> Employee and child(ren) <input type="radio"/> Family <input type="radio"/> NO COVERAGE (complete waiver)	Plan name		
1. Prior medical coverage during the past 18 months (individual or other group coverage)? <input type="radio"/> N <input type="radio"/> Y			
Prior medical insurance carrier name	Policy #	Prior coverage type: <input type="radio"/> Employee only <input type="radio"/> Employee and spouse <input type="radio"/> Employee and child(ren) <input type="radio"/> Family	Effective date ___/___/___ Term date ___/___/___
2. Other medical coverage in effect at the same time as this Humana coverage (individual or other group coverage)? <input type="radio"/> N <input type="radio"/> Y			
Other Medical Insurance carrier name	Policy #	Other coverage type: <input type="radio"/> Employee only <input type="radio"/> Employee and spouse <input type="radio"/> Employee and child(ren) <input type="radio"/> Family	Effective date ___/___/___ Term date ___/___/___
3. Medicare coverage:			
Employee coverage: <input type="radio"/> N <input type="radio"/> Y	Medicare ID	Effective date ___/___/___	Term date ___/___/___
Spouse coverage: <input type="radio"/> N <input type="radio"/> Y	Medicare ID	Effective date ___/___/___	Term date ___/___/___

Health Savings Account GA-72000-HA 3/2008

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? <input type="radio"/> N <input type="radio"/> 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.
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Dental GA-72000-HD 3/2008

Group #:	Benefit #:	Class/Div:	
Coverage type: <input type="radio"/> Employee only <input type="radio"/> Employee and spouse <input type="radio"/> Employee and child(ren) <input type="radio"/> Family <input type="radio"/> NO COVERAGE (complete waiver)	Plan name		
Prior dental coverage during the past 12 months (individual or other group coverage)? <input type="radio"/> N <input type="radio"/> Y			
Prior dental insurance carrier name	Prior coverage type: <input type="radio"/> Employee only <input type="radio"/> Employee and spouse <input type="radio"/> Employee and child(ren) <input type="radio"/> Family	Effective date ___/___/___ Term date ___/___/___	Policy #
Prior orthodontia coverage in the past 12 months? <input type="radio"/> N <input type="radio"/> Y	Prior carrier phone # ()		

Last name: _____

First name: _____

Basic Life Group #: _____ Benefit #: _____ Class/Div: _____ GA-72000-BL 3/2008

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?** No Yes
If no, complete waiver section.

Voluntary Life Group #: _____ Benefit #: _____ Class/Div: _____ GA-72000-VL 3/2008

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: _____ GA-72000-VS 3/2008

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

Medical Health History GA-72000-MH 3/2008

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

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|---|---|---|
| 1. Within the past 24 months have you or any dependent to be covered been diagnosed or been treated for an illness or injury, had surgery or hospitalization recommended, or are currently pregnant? <input type="radio"/> N <input type="radio"/> Y | 2. Within the past 24 months have you or any dependent to be covered been prescribed medication? <input type="radio"/> N <input type="radio"/> Y | 3. Have you or any dependent to be covered incurred medical expenses in excess of \$7,500 in the past 12 months? <input type="radio"/> N <input type="radio"/> 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) GA-72000-WV 3/2008

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 is evidence of this action.

I hereby waive coverage for (check all that apply): Medical for: <input type="radio"/> Myself <input type="radio"/> My spouse <input type="radio"/> My dependent child(ren) Dental for: <input type="radio"/> Myself <input type="radio"/> My spouse <input type="radio"/> My dependent child(ren) Basic Life for: <input type="radio"/> Myself <input type="radio"/> My spouse <input type="radio"/> My dependent child(ren) Vision for: <input type="radio"/> Myself <input type="radio"/> My spouse <input type="radio"/> My dependent child(ren) Health Savings Account for: <input type="radio"/> Myself	I decline to apply for group coverage because of: <input type="radio"/> Spousal coverage <input type="radio"/> Medicare supplement <input type="radio"/> Individual coverage <input type="radio"/> Coverage under another carrier's plan provided by my employer <input type="radio"/> Other:
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Agreement GA-72000-AA 3/2008

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.
- 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.
- 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 for the purposes of depositing any contributions.
- Any intentional 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.
- Medical coverage will not be declined due to health status.
- I have received a copy of the plan provider directory and disclosure that includes provider limitation rules and any financial arrangements with providers.

Last name: _____

First name: _____

Agreement

GA-72000-AA 3/2008

Authorization

My dependents and I authorize any third party to have information regarding myself and my dependents. 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.

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 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, the recipient may redisclose it and the information may not be protected by federal and state privacy requirements.
- 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 and I have the right to revoke this authorization at any time by writing to Humana's Privacy Office.

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.

GA-72000-SA 3/2008

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.

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.)