Humana Large Group Employee Enrollment Form

The offering comany(ies) listed on the signature page, severally or collectively, as the content may require, are referred to in this application as "Humana". Print clearly and completely fill in each applicable circle.

Company name

Company city

State KY

Office use only

Qualifying event:
❍ Open Enrollment ❍ Re-hire
❍ New hire ❍ Changed to full time status

Qualifying event date (MM/DD/YYYY) / /

Benefit effective date (MM/DD/YYYY) / /

Employee 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 state ❍ Full-time employee ❍ Retiree

Date of full-time hire (MM/DD/YYYY) / /

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

Primary care physician name

Primary care physician ID #

Current patient?

HMO/POS only ❍ Yes ❍ No

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 (18 or older) ❍ Disabled If disabled, indicate reason: _____

Primary care physician name

Primary care physician ID #

Current patient?

HMO/POS only ❍ Yes ❍ No

Primary dentist name

Current patient?

DHMO ❍ Yes ❍ No

Last name: | First name:

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 (18 or older) ❍ Disabled If disabled, indicate reason: _____

Primary care physician name | Primary care physician ID # | Current patient?

HMO/POS only ❍ Yes ❍ No

Primary dentist name | Current patient?

DHMO ❍ 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 (18 or older) ❍ Disabled If disabled, indicate reason: _____

Primary care physician name | Primary care physician ID # | Current patient?

HMO/POS only ❍ Yes ❍ No

Primary dentist name | Current patient?

DHMO ❍ 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 (18 or older) ❍ Disabled If disabled, indicate reason: _____

Primary care physician name | Primary care physician ID # | Current patient?

HMO/POS only ❍ Yes ❍ No

Primary dentist name | Current patient?

DHMO ❍ Yes ❍ No

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

Street address

Apt / Suite / PO box number

City | State | Zip code | County / Parish

Medical

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

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

Plan name | Network name

If HMO or POS plan, complete required information in employee & dependent sections

Last name: | First name:

- Will you or any covered family member have any other medical coverage, such as Medicare or a spouse's medical coverage in effect at the same time as this Humana coverage? ❍ Yes ❍ No If yes, list all:

Medicare ID or medical carrier name:

Starting date (MM/DD/YYYY) / /

End date, if applicable (MM/DD/YYYY) / /

Covered member (check all that apply)
❍ Employee
❍ Spouse
❍ Child(ren)

Medicare ID or medical carrier name:

Starting date (MM/DD/YYYY) / /

End date, if applicable (MM/DD/YYYY) / /

Covered member (check all that apply)
❍ Employee
❍ Spouse
❍ Child(ren)

- Besides those listed above, within the last 18 months, have you or any covered family member had any medical coverage, such as Medicare or a spouse's medical coverage? ❍ 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) / /

Covered member (check all that apply)
❍ Employee
❍ Spouse
❍ Child(ren)

Prior medical carrier name:

Starting date (MM/DD/YYYY) / /

End date, if applicable (MM/DD/YYYY) / /

Covered member (check all that apply)
❍ Employee
❍ Spouse
❍ Child(ren)

Dental

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

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

Plan name

- Within the past 12 months, have you or any covered family member 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) / /
Covered member (check all that apply) ❍ Employee ❍ Spouse ❍ Child(ren)

Prior dental carrier name:
Orthodontia coverage? ❍ Yes ❍ No
Starting date (MM/DD/YYYY) / /
End date, if applicable (MM/DD/YYYY) / /
Covered member (check all that apply) ❍ Employee ❍ Spouse ❍ Child(ren)

Employee primary care dentist name — Current patient?
Prepaid: ❍ Yes ❍ No

Dependents primary care dentist name — Current patient?
1 Prepaid: ❍ Yes ❍ No
2 Prepaid: ❍ Yes ❍ No
3 Prepaid: ❍ Yes ❍ No
4 Prepaid: ❍ Yes ❍ No

Last name: First name:

Basic life

Do you elect basic employee life?

❍ Yes ❍ No If no, complete waiver section

Office use only
Group # Benefit # Class/Div #

Last name First name MI

Primary Beneficiary

Secondary Beneficiary

Annual salary (if selecting life or short-term income protection): $, .00 Hours worked

Occupation

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

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

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Voluntary life

Do you elect voluntary employee life coverage?

❍ Yes ❍ No If no, complete waiver section

Office use only
Group # Benefit # Class/Div #

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

Last name First name MI

Primary Beneficiary

Secondary Beneficiary

Annual salary (if selecting life or Short-Term Income Protection): $, Hours worked

Occupation

Voluntary dependent life selection (available only if employee 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

GN-72001-VL 1/2008 Reorder# GN-80124-VL 3/2008

Vision

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

Office use only
Group # Benefit # Class/Div #

Plan name

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Short term income protection

Office use only
Group # Benefit # Class/Div #

Do you elect Short-Term Income Protection coverage?

❍ Yes ❍ No If no, complete waiver section

Annual salary (if selecting life or Short-Term Income Protection): $, .00 Hours worked

Occupation

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Last name: | First name:

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'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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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) / /

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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. 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):

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)
Short Term Income Protection for:	❍ Myself		
Health savings account for:	❍ Myself		
Flexible health account for:	❍ Myself		
Flexible dependent care 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: _____
_____

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Last name:	First name:

Insuring companies KENTUCKY

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in this application as "Humana". For HumanaHMO and POS medical plans in Northern KY, coverage is provided by Humana Health Plan of Ohio, Inc. For any other PPO, HMO, or POS medical plans, coverage is provided by Humana Health Plan, Inc., a Health Maintenance Organization. For Classic medical plans and Standard Indemnity medical plans, Life, Vision and Short-Term Income Protection plans, insurance coverage is provided or administered by Humana Insurance Company of Kentucky. For Dental, insurance coverage is provided or administered by The Dental Concern, Inc. or CompBenefits Dental, Inc. CompBenefits Vision plan insured and administered by CompBenefits Insurance Company.

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 with in 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 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.
- Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Authorization

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.

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 any group coverage

Employee or legal representative signature _____ Date ☐☐ / ☐☐ / ☐☐☐☐

Name and relationship of legal representative _____