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".

• **Humana Health Plan**, Inc., 321 West Main Street, Louisville, KY 40202 • **Humana Insurance Company of Kentucky**, 500 West Main Street, Louisville, KY 40202 • **The Dental Concern, Inc.**, 500 West Main Street, Louisville, KY 40202 • **CompBenefits Dental, Inc.**, 100 Mansell Court East, Suite 400, Roswell, GA 30076 • **Kanawha Insurance Company**, 210 South White Street, P.O. Box 610, Lancaster, SC 29721-0610

For 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 and Life 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. Vision plans insured or administered by Humana Insurance Company of Kentucky or The Dental Concern, Inc. 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.

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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

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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

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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

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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 - **Humana Health Plan, Inc.,** 321 West Main Street, Louisville, KY 40202
Humana Insurance Company of Kentucky, 500 West Main Street, Louisville, KY 40202

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 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

Start date (MM/DD/YYYY)
/ /

End date (MM/DD/YYYY)
/ /

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

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

Annual amount elected:
$, .00

Start date (MM/DD/YYYY)
/ /

End date (MM/DD/YYYY)
/ /

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

Dental - **The Dental Concern, Inc.,** 500 West Main Street, Louisville, KY 40202
CompBenefits Dental, Inc., 100 Mansell Court East, Suite 400, Roswell, GA 30076

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

In the event that an application is submitted outside of an open enrollment period, without a qualifying event, or by submitting an incomplete enrollment form Humana reserves the right to delay coverage.

Basic Life / AD&D - **Humana Insurance Company of Kentucky,** 500 West Main Street, Louisville, KY 40202
Kanawha Insurance Company, 210 South White Street, P.O. Box 610, Lancaster, SC 29721-0610

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:

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.
- This authorization shall be valid for twenty-four (24) months from the date shown below and I have the right to revoke this authorization at any time by writing to Humana's Privacy Office.

Authorization for Release of Medical Records for Life or Disability

If my dependents or I have selected life or disability, I authorize Humana, its reinsurer or its legal representatives, and its affiliates to have information. Any information obtained will not be released by the company checked below 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.

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 __ __/__ __/__ __ __ __

Please Note: If applying for life products through an agent, location of signature is required.

City: _____ **State:** _____ **County:**_____

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.