Large group employee enrollment form

The offering company(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

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 status ○ 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: _____

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

Employee social security number ☐☐☐ - ☐☐ - ☐☐☐☐

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

- **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)

Employee social security number ___ - ___ - ____

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: _____

HMO/POS only: Primary care physician name | 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 (18 or older) ○ Disabled If disabled, indicate reason: _____

HMO/POS only: Primary care physician name | 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 (18 or older) ○ Disabled If disabled, indicate reason: _____

HMO/POS only: Primary care physician name | 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 (18 or older) ○ Disabled If disabled, indicate reason: _____

HMO/POS only: Primary care physician name | Primary care physician ID # | Current patient? ○ 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

Employee social security number [ ][ ][ ] - [ ][ ] - [ ][ ][ ][ ]

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 social security number ☐☐☐ - ☐☐ - ☐☐☐☐

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.

(Check all that apply. Some coverages included in this waiver may not be available in the plan your employer has selected - please see your benefits administrator for more information):

I hereby:

Waive medical for:	O Myself	O My spouse	O My dependent (child)ren
Waive dental for:	O Myself	O My spouse	O My dependent (child)ren
Waive basic life for:	O Myself	O My spouse	O My dependent (child)ren
Waive voluntary life for:	O Myself	O My spouse	O My dependent (child)ren
Waive short term income protection for:			O Myself
Waive health savings account for:			O Myself
Waive flexible health account for:			O Myself
Waive flexible dependent care account for:			O Myself

I decline to apply for group coverage because of:
- O Spousal coverage
- O Medicare supplement
- O Individual coverage
- O Coverage under another carrier's plan provided by my employer
- O 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 dental or life with any future application for coverage.

AL-80124-WV 5/2005	AZ-80124-WV 8/2005	AR-80124-WV 5/2005	CA-80124-WV	CO-80124-WV 5/2005
FL-80124-WV	GA-80124-WV 8/2005	IL-80124-WV 6/2005	IN-80124-WV 6/2005	KS-80124-WV 3/2005
KY-80124-WV 7/2005	LA-80124-WV 7/2005	MI-80124-WV 7/2005	MS-80124-WV 7/2005	MO-80124-WV 8/2005
NE-80124-WV 8/2005	NV-80124-WV 9/2005	OK-80124-WV 9/2005	SC-80124-WV 9/2005	TN-80124-WV 7/2005
VA-80124-WV	WI-80124-WV 5/2005			

Reorder# GN-80124-WV1 1/2006

Employee social security number ☐☐☐ - ☐☐ - ☐☐☐☐

Insuring companies

INDIANA

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 Southeastern Indiana Medical plans offered by Humana Health Plan of Ohio, Inc. All other HMO and POS plans offered by Humana Health Plan, Inc. PPO and Classic Medical plans and Life and Short-Term Income Protection plans insured by Humana Insurance Company. Standard PPO Value, HDHP PPO Value and CoverageFirst PPO Value medical plans insured or administered by Emphesys Insurance Company. Dental plans insured by HumanaDental Insurance Company.

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.

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.
- 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 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.

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

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

Name and relationship of legal representative _____