Print Form

Visit us at www.humana.com or www.humanadental.com

Humana Employee Enrollment Form - 2-50 Employees MISSOURI

Humana Insurance Company, Humana Dental Insurance Company, CompBenefits Insurance Company •
1100 Employers Boulevard • Green Bay, WI 54344 • 1-866-427-7478

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in this application as "Humana".

HMO plans offered by Humana Health Plan, Inc. 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 or CompBenefits Insurance Company. 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

Enrollment Information

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

EMPLOYEE INFORMATION: **HOURS WORKED PER WEEK:** ❍ **RETIREE** **DATE OF FULL-TIME HIRE:** _ _ / _ _ / _ _ _ _

SSN #	Street address		APT / Suite / Box
City	State	Zip code	Phone # ( )
Language: ❍ English ❍ Spanish	Email address		

Medical

Group #: Benefit #: Class/Div:

The group plan/policy includes coverage for contraceptives unless your employer has chosen to exclude that coverage because such coverage is contrary to your employer's moral, ethical, or religious beliefs or tenets. You have the right to include coverage of contraceptives, even if your employer has chosen to exclude such coverage. Please ask your employer if your plan offers contraceptive coverage and then select from the following options:

a. If your employer has chosen to include contraceptive coverage and you wish to have such coverage, you do not have to do anything.

b. If your employer has chosen to exclude contraceptive coverage and you wish to include such coverage, contact us to add contraceptive coverage to your plan.

c. If your employer's plan selection includes contraceptive coverage, you have the right to exclude coverage of prescription drugs or devices for use as contraceptives, if such coverage is contrary to your moral, ethical, or religious beliefs or tenets. Contact us to exclude contraceptive coverage from your plan.

You must submit your request to include or exclude coverage of contraceptives to us by verbal, written or electronic means, within 31 days of your initial or annual enrollment or policy anniversary date.

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

1. Prior medical coverage during the past 18 months (individual or other group coverage)? ❍ N ❍ Y

Prior medical insurance carrier name	Policy #	**Prior coverage type:** ❍ Employee only ❍ Employee and spouse ❍ Employee and child(ren) ❍ Family	Effective date _ _ / _ _ / _ _ _ _ Term date _ _ / _ _ / _ _ _ _

2. Other medical coverage in effect at the same time as this Humana coverage (individual or other group coverage)? ❍ N ❍ Y

Other Medical Insurance carrier name	Policy #	**Other coverage type:** ❍ Employee only ❍ Employee and spouse ❍ Employee and child(ren) ❍ Family	Effective date _ _ / _ _ / _ _ _ _ Term date _ _ / _ _ / _ _ _ _

3. Medicare coverage:

Employee coverage: ❍ N ❍ Y	Medicare ID	Effective date _ _ / _ _ / _ _ _ _	Term date _ _ / _ _ / _ _ _ _
Spouse coverage: ❍ N ❍ Y	Medicare ID	Effective date _ _ / _ _ / _ _ _ _	Term date _ _ / _ _ / _ _ _ _

Last name:	First name:

Health Savings Account

Group #: | Benefit #: | Class/Div:

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? ❍ N ❍ 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.

Dental

Group #: | Benefit #: | Class/Div:

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

Prior dental coverage during the past 12 months (individual or other group coverage)? ❍ N ❍ Y

Prior dental insurance carrier name	**Prior coverage type:** ❍ Employee only ❍ Employee and spouse ❍ Employee and child(ren) ❍ Family	Effective date _ _ / _ _ / _ _ _ _	Policy #
Prior orthodontia coverage in the past 12 months? ❍ N ❍ Y		Term date _ _ / _ _ / _ _ _ _	Prior carrier phone # ( )

Basic Life

Group #: | Benefit #: | Class/Div:

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:

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:

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

Evidence of Health Status

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

Complete this section for employees and dependents enrolling for medical coverage who are members of groups with 2-50 applicants and applicants requesting Life insurance over the guarantee issue amount, and all late enrollees applying for Life coverage.

1. Are you or any dependent currently under any treatment or prescribed medications? ❍ N ❍ Y

2. Within the past 5 years, have you or any eligible dependent to be covered been diagnosed with, counseled, consulted or treated by a doctor for any of the following:

a	Coronary artery disease, chest pain, or any disease of the arteries or blood vessels; phlebitis; high blood pressure?	❍ N ❍ Y	f	Diabetes; liver or thyroid disease; or enlargement of the lymph nodes?	❍ N ❍ Y
b	Nervous, mental or emotional disorder; convulsions; epilepsy; unconsciousness?	❍ N ❍ Y	g	Stomach, gall bladder, intestinal or colon disorders?	❍ N ❍ Y
c	Asthma or other disease of lungs or respiratory organs?	❍ N ❍ Y	h	Rheumatoid arthritis or back disorders?	❍ N ❍ Y
d	Kidney stones; disease of kidney, bladder, male or female organs; or infertility?	❍ N ❍ Y	i	Paralysis, or any other physical impairment or deformity?	❍ N ❍ Y
e	Cancer, and/or cancerous tumor? (state type & part of body in details section below)	❍ N ❍ Y	j	Alcoholism or drug habit, or been a member of Alcoholics Anonymous?	❍ N ❍ Y

3. Have you or any dependent been positively diagnosed or received treatment for an immune system disorder (i.e. Lupus, ITP), AIDS or an AIDS-related complex? ❍ N ❍ Y

4. During the past 5 years, have you or any dependent had hospitalization or surgery scheduled or completed, had any injury, illness, medical attention or medical advice from a doctor or treatment for any reason not already mentioned? ❍ N ❍ Y

5. Are you or any dependent to be covered pregnant? ❍ N ❍ Y

If you answered "yes" to any of the questions above, please provide details below and specify the question #. 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 _ _ / _ _ / _ _ _ _

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. 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):	I decline to apply for group coverage because of:
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) Vision for: ❍ Myself ❍ My spouse ❍ My dependent child(ren) Health Savings Account for: ❍ Myself	❍ Spousal coverage ❍ Medicare supplement ❍ Individual coverage ❍ Coverage under another carrier's plan provided by my employer ❍ Other:

Agreement

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.

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 group coverage.

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.)

Print Form Reset Form