**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

| Internal use only |
| --- |
| Group number: |

# Small Group Employer Application (2-50 employees)

**KENTUCKY**
**HUMANA / HUMANADENTAL**

Please refer to your proposal to complete this application. This document will form part of any contract issued. Print clearly in black ink, and answer all questions or indicate "not applicable."

## Your Business Profile

Business name | Federal tax ID number

Location address (not a P.O. Box)

City | State | Zip code | County

Do you have more than one location? ❍ No ❍ Yes

Billing address (if different)

City | State | Zip code | County

Nature of business or SIC number | Date company established

Business status: ❍ Corporation ❍ Partnership ❍ Sole Proprietorship ❍ Other: (explain)

Business phone number | Fax number

Management contact | Administrative contact

Management contact e-mail address

Management contact: Mother's maiden name _____
*This will be used to gain access to the Employer Self-Service Center on www.Humana.com.*

## General Eligibility

Requested effective date | How many employees are on your payroll?

How many hours per week must your employees work to be eligible? (select between 20 and 40 hours)

Do you want to exclude a class of employees? ❍ No ❍ Yes

If yes, check class to exclude: (Options vary by plan. Refer to the Underwriting Requirements for each plan.)

❍ union ❍ non union ❍ hourly ❍ salary ❍ management ❍ non-management

How long must employees wait after hire date to become eligible? ❍ 0 days ❍ 30 days ❍ 60 days ❍ 90 days ❍ Other, specify:

How many employees are eligible for coverage?

New employee effective date provision: ❍ First of month following waiting period (required for Medical HMO and POS plans) ❍ Immediately following waiting period

On all plans, the employee termination date coincides with the effective date provision.

Do you want to cover dependent children up to the age of 25, regardless of student status? ❍ No ❍ Yes (additional cost if selected)

Is this employer required to comply with COBRA regulation? ❍ No ❍ Yes

Is this employer required to comply with state continuation regulation? ❍ No ❍ Yes

Are any present or former employees/dependents currently on or eligible to elect COBRA/State Continuation? ❍ No ❍ Yes

If yes, enter information below. Attach a separate sheet if necessary.

| Name of applicant | Qualifying event (e.g., termination of employment, divorce, etc.) | Date of qualifying event | Date COBRA or State Continuation coverage terminates |
| --- | --- | --- | --- |
| | | | |
| | | | |
| | | | |

## Employer Agreement

You the employer, understand, agree and represent:

- You have read this document and the information you provided is accurate and complete to the best of your knowledge and belief and can be substantiated by your business records.
- You have received and reviewed a proposal and the applicable regulatory information required by your state.
- Neither you nor the agent/broker/producer has the authority to waive a complete answer to any question, determine coverage or insurability, alter any contract, bind us by making any promise or representation, or waive any of our other rights or requirements. No waiver or change will bind us unless signed by an authorized officer of our company.
- The first month's estimated premium (which may include a monthly administrative fee), and fully completed enrollment information for all eligible persons requesting insurance coverage must be submitted with this application before action is taken on this application. Unless we are informed differently, we will perform a one-time electronic check conversion of the first month's premium payment from the account and for the amount designated on the binder check.
- You will collect any employee contribution toward premium. Our acceptance of premium does not guarantee coverage.
- You will provide the documentation requested by us which establishes that all eligibility, underwriting, and participation requirements of the plan are met.
- Only individuals who meet the eligibility requirements of the plan are eligible to maintain coverage.
- Intentional fraud or intentional misrepresentation of a material fact may void, reduce or increase past premium, or terminate an individual's coverage or group's coverage.
- If choosing the HDHP Indexing plan, deductible and out of pocket amounts are established by IRS guidelines. Adjustments to these amounts by the IRS will be made to the policy, without notice, upon renewal of the group.
- 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.

This document will form part of any contract issued. Coverage is not in effect unless and until you receive written notification from us.

If this application is declined, we will return the premium deposit submitted with this application.

**Do not cancel any current group coverage until you receive written notice from us that we have issued coverage.**

Dated on:_____ By:_____
(month, date, year) (employer signature)

Dated at:_____ By:_____
(city and state) (title)

## Agent/Producer Information

| **1. Agent/Agency of Record (for commissions and correspondence):** | **2. Agent/Agency of Record (for split-commissions):** |
|---|---|
| Name (print) | Name (print) |
| Tax ID / Social Security Number / Humana Agent Number | Tax ID / Social Security Number / Humana Agent Number |
| Commission split: ❍ No ❍ Yes<br>If yes, percentage: (total should equal 100%) | Percentage of sales: ❍ No ❍ Yes<br>If yes, percentage: (total should equal 100%) |
| **1. Writing Agent/Producer:** | **2. Writing Agent/Producer:** |
| Name (print) | Name (print) |
| Social Security Number | Social Security Number |
| Commission split: ❍ No ❍ Yes<br>If yes, percentage: (total should equal 100%) | Percentage of sales: ❍ No ❍ Yes<br>If yes, percentage: (total should equal 100%) |

### General Agency

General agency information pertains to ❍ Agent/Agency of Record #1 ❍ Agent/Agency of Record #2

Name (print) Tax ID / Humana Agent Number

Address City State Zip code

As the Writing Agent/Broker/Producer, I acknowledge that I am responsible to meet with the employer submitting this application 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 employer in the Regulatory Pre-enrollment Disclosure or other plan literature.

Writing Agent's Signature:_____ Date:_____

## The following applies to all companies and products

The companies listed on this Employer Group Application, severally or collectively as the context may require, are referred to in this application as we, us and our.

You, the participating employer, policyholder, contractholder, or group plan sponsor, intend to establish, sponsor, and endorse an employee benefit plan which will be governed by Employee Retirement Income Security Act of 1974 (ERISA). You are the ERISA plan administrator.

Small employer means a person, firm, corporation, partnership or association actively engaged in business, which employed an average of at least two but not more than 50 employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year. Entities that are affiliated companies or that are eligible to file a combined tax return for the purpose of taxation, are considered one employer.

You agree to make available your records which we determine are relevant to this application and group coverage for inspection by the Trustee, Administrator, us or our representative during your normal business hours.

As claims administrator, we shall, in accordance with state and federal law, 1) interpret Policy, Group Plan, or Group Contract provisions, 2) make decisions regarding eligibility for coverage and benefits, and 3) resolve factual questions relating to coverage and benefits.

You understand and agree that failure to remit and pay premium when due will be considered a default in premium payment. A grace period of 31 days will be allowed for payment of each premium due. If coverage is terminated by us for non-payment of premium, you will still owe and we will collect all due premium. If the required premium is not paid by the end of the 31-day grace period, we reserve the right to collect premium for the grace period. We may terminate your coverage according to the termination section of the Policy or Group Plan. Except for non-payment of premium or when a group or individual is not or has not been eligible for coverage, you will be provided with a 30 day advance written notice, unless a greater period is expressly specified in the Policy. If coverage is terminated by us for non-payment of premium, you will still owe and we will collect all due premium including premium for the grace period.

You understand and agree that your coverage is renewed on a monthly basis subject to timely payment of premium. We reserve the right to change the premium rates on any premium due date, as permitted by applicable law, after your insurance has been in effect under the Policy for 12 consecutive months. You will receive advance written notice.

For you to remain eligible for the Policy or Group Plan, the eligibility, underwriting and participation requirements must be maintained, for each respective coverage. Failure to maintain the plan eligibility, underwriting and participation requirements will terminate your coverage under the Policy or Group Plan. Other termination provisions are stated in the Policy or Group Plan.

Based upon our standard underwriting practice, we may require an employee or dependent to submit Evidence of Health Status. We have the right to use the information provided by you and any applicant (employee or dependent) to determine whether coverage will be provided, to determine eligibility and to establish appropriate premiums. Any health related information that has been provided will not be used to decline medical coverage unless permitted by law.

HUMANA.
*Guidance* when you need it most

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, Life and Short-Term Income Protection plans, insurance coverage is provided or administered by Humana Insurance Company of Kentucky.

HUMANA.
*Specialty Benefits*

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.

# Humana Group Medical

**KENTUCKY**
**EMPLOYER GROUP APPLICATION**

For PPO, HMO, or POS Medical plans, coverage is provided by Humana Health Plan, Inc., 321 West Main Street, Louisville, KY 40202, a Health Maintenance Organization. For Classic Medical plans and Standard Indemnity medical plans, insurance coverage is provided or administered by Humana Insurance Company of Kentucky, 500 West Main Street, Louisville, KY 40202.

## Plan Selection (To complete this information, refer to your proposal.)

| | Plan 1 | Plan 2 | Plan 3 |
|---|---|---|---|
| **Plan name** (as shown on your proposal) | | | |
| **Office visit copayment** (if applicable) | $ | $ | $ |
| **Coinsurance** (if applicable) | Participating (In) : %_____<br>Non-participating (Out): % _____ | Participating (In) : %_____<br>Non-participating (Out): % _____ | Participating (In) : %_____<br>Non-participating (Out): % _____ |
| **Deductible** (if applicable) | Participating: $<br>Non-participating: $ | Participating: $<br>Non-participating: $ | Participating: $<br>Non-participating: $ |
| **Out-of-pocket limit** (if applicable) | Participating: $<br>Non-participating: $ | Participating: $<br>Non-participating: $ | Participating: $<br>Non-participating: $ |
| **Network name** (if applicable) | | | |

## Plan Riders (Please refer to your proposal for rider availability with plan selected.)

| | | | |
|---|---|---|---|
| **Deductible Carryover Credit** | ○ No ○ Yes | ○ No ○ Yes | ○ No ○ Yes |
| **Supplemental Accident** | ○ No ○ Yes | ○ No ○ Yes | ○ No ○ Yes |
| **Prescription Drug/Retail Card** (Level 1 / 2 / 3 / 4) | $_____/$_____/$_____/_____% | $_____/$_____/$_____/_____% | $_____/$_____/$_____/_____% |
| **Prescription Drug/Retail Card** (Group A / B / C / D) | $____a/$____a/$____a/$____a | $____a/$____a/$____a/$____a | $____a/$____a/$____a/$____a |
| **Other:** | ○ No ○ Yes | ○ No ○ Yes | ○ No ○ Yes |

## Humana PPO Options (Humana Health Plan, Inc.)

**Is this employer a GLI/Chamber member?** ○ No ○ Yes

## Underwriting Requirements

- You may not sponsor a medical plan from a carrier other than Humana.
- Medical coverage is available to employers with two or more enrolled employees.
- If the only employees of a two-life group are husband and wife, each must enroll separately as an employee and maintain eligibility. The group is only eligible if a bona fide business entity exists.
- If less than 10 employees are enrolled, you must submit evidence of health status for all employees and dependents. We will not use the evidence of health status to decline medical coverage.
- Minimum employer contribution toward employee premium is 50%.
- Retiree coverage is available to employers with 26 or more enrolled employees.
- Minimum age for retiree coverage is 65 for employers with 26 to 50 enrolled employees.
- There are no excluded class options for small group (2-50) medical coverage.
- If you do not maintain eligibility, underwriting, and participation requirements, we will terminate your coverage.
- Participation
- non-contributory plans – 100%
- contributory plans – 75%

## Group Information

How much will you contribute to premium? Employee _____% Dependent _____%

Are there any other entities associated with this company that are eligible to file a combined tax return? ❍ No ❍ Yes
If yes, enter information below.

| Company Name | Total Employees |
|---|---|
| | |
| | |

Will your employees have access to another carrier's medical coverage by virtue of their employment with you? ❍ No ❍ Yes
If yes, name of carrier:

Did you have prior group medical coverage? ❍ No ❍ Yes If yes, submit most recent carrier billing with effective and termination dates.

How many medical carriers have you had in the past five years?

Is the agent/broker/producer representing you for this application your current agent/broker/producer of record? ❍ No ❍ Yes

Provide the current and renewal medical insurance premium rates below and attach a copy of your most recent premium bill.
Date of renewal:

| **Current Plan 1 current carrier rates:** | **Current Plan 2 current carrier rates:** |
|---|---|
| Employee: $_____ Spouse: $_____<br>Child(ren): $_____ Family: $_____ | Employee: $_____ Spouse: $_____<br>Child(ren): $_____ Family: $_____ |
| Plan design: | Plan design: |
| Office visit copay: | Office visit copay: |
| Per confinement copay: | Per confinement copay: |
| Deductible: • Participating _____<br>• Non-participating _____ | Deductible: • Participating _____<br>• Non-participating _____ |
| Out-of-pocket: • Participating _____<br>• Non-participating _____ | Out-of-pocket: • Participating _____<br>• Non-participating _____ |
| Coinsurance stoploss: • Participating _____<br>• Non-participating _____ | Coinsurance stoploss: • Participating _____<br>• Non-participating _____ |
| Emergency room copay: | Emergency room copay: |
| Prescription drug benefit: | Prescription drug benefit: |
| Do you as the employer currently fund any of the plan deductible for the employees? ❍ No ❍ Yes<br>If yes, how much of the deductible do you fund?_____ | Do you as the employer currently fund any of the plan deductible for the employees? ❍ No ❍ Yes<br>If yes, how much of the deductible do you fund?_____ |
| **Renewal rates:** In the parentheses, please indicate the number of employees enrolled in each tier, if available.<br>Employee ( ): $_____ Spouse ( ): $_____<br>Child(ren) ( ): $_____ Family ( ): $_____ | **Renewal rates:** In the parentheses, please indicate the number of employees enrolled in each tier, if available.<br>Employee ( ): $_____ Spouse ( ): $_____<br>Child(ren) ( ): $_____ Family ( ): $_____ |

1. Has any employee been unable to work 10 or more consecutive days in the past 12 months due to an illness or injury? ❍ No ❍ Yes
2. Is any employee presently not performing his or her duties on a full-time basis due to an illness or injury? ❍ No ❍ Yes
3. To the best of your knowledge, is there any employee, individual in a retiree class, dependent (spouse or child), COBRA beneficiary, or individual within their COBRA/State Continuation election period:
   - ❍ confined at home, in a hospital, or in a treatment facility;
   - ❍ who incurred more than $10,000 of medical expenses in the past 24 months;
   - ❍ who has been advised by a physician or licensed practitioner within the last 90 days to have surgery or be hospitalized;
   - ❍ who received treatment, had treatment recommended, or had medication prescribed by a doctor, psychiatrist, psychologist or other licensed practitioner within the past 24 months for any of the following: (check all that apply)
     - ❍ Alcohol or drug abuse or dependence, or psychological disorder
     - ❍ Cancer or cancerous tumor
     - ❍ Heart or vascular disease or stroke
     - ❍ Diabetes or any disease or disorder of the kidneys, liver or lungs
     - ❍ Systemic disease including Lupus, Multiple Sclerosis, or Muscular Dystrophy. Excludes Human Immunodeficiency Virus (HIV) infection.
     - ❍ Organ transplant (other than corneal)
4. Has any employee, individual in a retiree class, dependent (spouse or child), COBRA beneficiary, or individual within their COBRA/State Continuation election period, been diagnosed or received treatment for an immune system disorder (i.e. Lupus, ITP), AIDS or an AIDS-related complex?

## Group Information (continued)

If you answered yes to questions 1-4 above, please indicate the question number and explanation.

| Question # | Member Status* | Age | Medical Condition/ Diagnosis | Date(s) of Treatment | Medication Name/ Dosage | Past/Current/Future Treatment |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |

** Member Status: E=Employee D=Dependent C=COBRA/State Continuation R=Retiree Class*

Has your company, at any time during the past 24 months, had medical coverage terminated or a renewal of medical coverage refused?
❍ No ❍ Yes If yes, please explain:

Have any medical benefits now, or within the past 24 months, been funded by you in any manner other than health insurance premium payment? ❍ No ❍ Yes If yes, please provide details and attach medical claims experience for the applicable time period up to 24 months.

## Retiree Information

Are you offering coverage to retirees? ❍ No ❍ Yes If yes, required age: Minimum years of service:

Print Form

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

# Humana Employee Enrollment Form - 2-50 Employees KENTUCKY

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

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, Life 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. For Dental, insurance coverage is provided or administered by CompBenefits Dental, Inc. Vision plans insured or administered by Humana Insurance Company of Kentucky or The Dental Concern, Inc.

**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: |

Do you want to cover dependent children up to the age of 25, regardless of student status? ○ No ○ Yes (additional cost if selected)

**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:

For PPO, HMO, or POS Medical plans, coverage is provided by **Humana Health Plan, Inc.,** 321 West Main Street, Louisville, KY 40202, a Health Maintenance Organization. For Classic Medical plans and Standard Indemnity medical plans, insurance coverage is provided or administered by **Humana Insurance Company of Kentucky,** 500 West Main Street, Louisville, KY 40202.

**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:

For Dental, insurance coverage is provided or administered by **The Dental Concern, Inc.**, 500 West Main Street, Louisville, KY 40202. For Dental, insurance coverage is provided or administered by **CompBenefits Dental, Inc.**, 100 Mansell Court East, Suite 400, Roswell, GA 30076.

| **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 # ( ) |

Will the insurance coverage applied for be used to replace any existing group life coverage? ○ N ○ Y

## Basic Life

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

For Life plans, insurance coverage is provided or administered by **Humana Insurance Company of Kentucky**, 500 West Main Street, Louisville, KY 40202.

| 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?** ○ N ○ Y If no, complete waiver section. |
|---|---|---|

## Voluntary Life

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

For Life plans, insurance coverage is provided or administered by **Humana Insurance Company of Kentucky**, 500 West Main Street, Louisville, KY 40202.

| 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:

For Vision, plans are insured or administered by **Humana Insurance Company of Kentucky,** 500 West Main Street, Louisville, KY 40202, or **The Dental Concern, Inc.**, 100 Mansell Court East, Suite 400, Roswell, GA 30076.

| **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 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 or treatment for any reason not already mentioned? | ○ N ○ Y |
| **5.** Are you or any dependent to be covered pregnant? | ○ N ○ Y |

| Last name: | First name: |
|---|---|

## Evidence of Health Status

**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 _ _ / _ _ / _ _ _ _ |

## 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) | ○ Spousal coverage |
| Dental for: ○ Myself ○ My spouse ○ My dependent child(ren) | ○ Medicare supplement |
| Basic Life for: ○ Myself ○ My spouse ○ My dependent child(ren) | ○ Individual coverage |
| Vision for: ○ Myself ○ My spouse ○ My dependent child(ren) | ○ Coverage under another carrier's plan provided by my employer |
| Health Savings Account for: ○ Myself | ○ 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.
- 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.
- 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.
- Intentional fraud or intentional misrepresentation of a material fact may void, reduce or increase past premium, or terminate an individual's coverage or group's coverage.
- 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 Humana, its reinsurer or its legal representatives, and its affiliates to have information regarding myself–this includes any medical or non-medical 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.

**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.
- 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.**

| Last name: | First name: |
|---|---|

**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.)