Humana employee enrollment application
Dental, life and short-term income protection

ILLINOIS

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, Classic and Indemnity Medical plans and LIfe and Short Term income protection plans insured or administered by Humana Insurance Company. Dental PPO and Traditional Preferred plans insured or administered by HumanaDental Insurance Company or Humana Insurance Company. Dental Prepaid plans underwritten by The Dental Concern, Ltd.

Please print clearly. Dental Group number | Benefit number | Class/Division

Proposed Effective Date (MMDDYYYY)

Company name

Company city State

Employee information

IL-80124-GN

Last name First name MI

Social Security number Date of birth Phone number

Gender: ❑ Female ❑ Male E-mail address

Street address Apt / Suite / PO box number

City State Zip code County

Language of choice: ❑ English ❑ Spanish

Employment status: ❑ Full-time employee: number of hours worked per week Date of full-time hire ❑ Retiree

Are you disabled or unable to perform normal activities? ❑ No ❑ Yes If yes, indicate reason

Dependent information

IL-80124-DP

Please enter information for each dependent, including spouse, applying for coverage. For additional dependents, copy and attach an additional Dependent Information form.

1. Last name First name MI

   Date of birth Gender: ❑ Female ❑ Male Relationship: ❑ Spouse ❑ Child ❑ Other:

   Dependent status (if applicable): ❑ Full-time student ❑ Disabled If disabled, indicate reason

   Prepaid Only: Dentist name Current patient? ❑ No ❑ Yes

2. Last name First name MI

   Date of birth Gender: ❑ Female ❑ Male Relationship: ❑ Spouse ❑ Child ❑ Other:

   Dependent status (if applicable): ❑ Full-time student ❑ Disabled If disabled, indicate reason

   Prepaid Only: Dentist name Current patient? ❑ No ❑ Yes

Dental

IL-80124-HD

Coverage type: ❑ Employee only ❑ Employee and spouse ❑ Employee and child(ren) ❑ Family ❑ Other

Plan name

Prepaid Only: Dentist name Network name Current patient? ❑ No ❑ Yes

Within the past 12 months, have you had any individual or other group dental coverage? ❑ No ❑ Yes Orthodontia coverage? ❑ No ❑ Yes

Effective date Term date Prior coverage type: ❑ Employee only ❑ Employee & spouse ❑ Employee & child(ren) ❑ Family

Basic Life

IL-80124-HL

Group number	Benefit number	Class/Division	

Primary beneficiary name Secondary beneficiary name

Class (employer will provide you with this information if needed) Annual salary (if applicable) $

Basic dependent life: ❑ Yes ❑ No If no, complete waiver section

Voluntary Life

Do you elect voluntary employee life coverage? ❑ No ❑ Yes Amount (minimum of $15,000) $ Annual salary $

Primary beneficiary name Secondary beneficiary name

Voluntary dependent life (available only if employee elects voluntary life coverage) Do you elect voluntary child(ren) life coverage? ❑ No ❑ Yes

Do you elect voluntary spouse life coverage? ❑ No ❑ Yes Amount (minimum of $5,000) $

Group number	Social Security number

Short-term income protection — IL-80124-SD

Do you elect short-term income protection coverage? ❑ Yes ❑ No Annual salary $

Class (employer will provide if needed)

Waiver (refusal of coverage) — IL-80124-HD

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 insurance coverage for (check all that apply):

❑ Dental for: ❑ Myself ❑ My spouse ❑ My dependent (child)ren

❑ Basic Life for: ❑ Myself ❑ My spouse ❑ My dependent (child)ren

❑ Short-term income protection 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:

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 coverage with any future application for coverage.

Agreement — IL-80124-AA

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 practitioner, hospital, clinic, veterans administration facility, other medical or medically-related facility, Pharmacy Benefit Manager, insurance, HMO or reinsuring company, the Medical Information Bureau, Inc., or the Consumer Reporting Agency having information regarding myself and my dependents, including information concerning, advice, diagnosis, treatment and care of physical, psychiatric, mental or emotional conditions, drug, substance or alcohol abuse or illness, and any other non-medical information, to give any and all such information to Humana or their legal representative.

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 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 any application, claim or as may be otherwise lawfully required, or as we may further authorize.
- We may request to receive a copy of this authorization.
- 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.

Signature—please sign below if enrolling or waiving group coverage

Employee signature _____ Date _____