Humana employee enrollment application—26-50 employees 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. Medical 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

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

   Social Security number Gender: ❑ Female ❑ Male Relationship: ❑ Spouse ❑ Child ❑ Other:

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

   HMO and POS only:

   Primary care physician Physician ID Current patient: ❑ No ❑ Yes

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

2. Last name First name MI Date of birth

   Social Security number Gender: ❑ Female ❑ Male Relationship: ❑ Spouse ❑ Child ❑ Other:

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

   HMO and POS only:

   Primary care physician Physician ID Current patient: ❑ No ❑ Yes

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

3. Last name First name MI Date of birth

   Social Security number Gender: ❑ Female ❑ Male Relationship: ❑ Spouse ❑ Child ❑ Other:

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

   HMO and POS only:

   Primary care physician Physician ID Current patient: ❑ No ❑ Yes

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

Group number | Social Security number

Medical IL-80124-SG

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

Plan name | Network name

HMO and POS only:

Employee primary care physician | Physician ID | Current patient: ❑ No ❑ Yes

Concurrent medical coverage:

Will you have any other group medical coverage, including Medicare, in effect at the same time as this Humana coverage? ❑ No ❑ Yes

Medical carrier name | Policy number

Carrier phone number | Medicare ID | Effective date | Term date

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

Prior medical coverage: (This section must be completed in order for Humana to process any medical claims.)

Within the past 18 months, have you had any individual or other group medical coverage, including Medicare? ❑ No ❑ Yes

Prior medical carrier name | Policy number

Prior carrier phone number | Medicare ID | Effective date | Term date

Prior coverage type: ❑ Employee only ❑ Employee and spouse ❑ Employee and child(ren) ❑ Family | Still in effect? ❑ No ❑ Yes

Dental IL-80124-HD

Group number	Benefit number	Class/Division

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

Plan name

Prepaid Only: Dentist name | Network | 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: ❑ No ❑ Yes 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) $

Short-term income protection IL-80124-SD

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

Class (employer will provide if needed)

Health savings account IL-80124-HA

Group number	Benefit number	Class/Division

If you have medical coverage under another plan, you may not be eligible for an HSA. Please check with your tax advisor for details.

Do you elect the health savings account? ❑ No ❑ Yes

For help filling out this section, use the enrollment application HSA worksheet.

1. How much were you allowed to contribute to any HSA in this calendar year to date? $
2. How much have you contributed to any HSA in this calendar year-to-date? $
3. How much do you wish to contribute to the HSA for the remainder of this calendar year? $
4. If your plan year spans two calendar years, how much are you allowed to contribute to your HSA for the portion of the plan year that falls in the second calendar year? $

Group number	Social Security number

Health savings account (continued)

5 How much have you already contributed to any HSA for the portion of your plan year that falls in the second calendar year? $

6 How much do you wish to contribute to your HSA for the portion of your plan year that falls in the second calendar year? $

7 Please provide the effective date of this HSA information (mm/01/yyyy) / 01 /

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.

Medical health history

IL-80124-MH

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

1. Within the last 24 months have you or any dependents to be covered consulted, received treatment, had medication prescribed by a doctor, psychiatrist, psychologist, or other practitioner or been diagnosed for: cancer, stroke, diabetes, heart or vascular disease, mental or emotional disorder, muscular or systemic disease (including, but not limited to arthritis or lupus), alcohol or drug use, liver, kidney, lung or intestinal disorder, infertility, transplant (recommended, pending, or completed), growth disorder, or have medical claims in excess of $5,000? ❑ No ❑ Yes

2. Within the last 24 months have you or any dependents to be covered consulted, received treatment, had medication prescribed by a doctor, psychiatrist, psychologist, or other practitioner, or been diagnosed for: Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), enlarged lymph nodes, or other immune system disorder? ❑ No ❑ Yes

3. Are you or any dependent to be covered pregnant, or been advised in the last 12 months that hospitalization, surgery, or treatment is needed or pending? ❑ No ❑ Yes

If you answered "yes" to any of the questions above, please provide details below and specify the question number. Attach additional signed and dated sheets if necessary.

Question number　Person treated last name　First name

Condition

List symptoms encountered

List treatments received

List medical tests administered

Medication(s) if any

Date condition was first diagnosed　Date last seen by a doctor for this condition

Question number　Person treated last name　First name

Condition

List symptoms encountered

List treatments received

List medical tests administered

Medication(s) if any

Date condition was first diagnosed　Date last seen by a doctor for this condition

Question number　Person treated last name　First name

Condition

List symptoms encountered

List treatments received

List medical tests administered

Medication(s) if any

Date condition was first diagnosed　Date last seen by a doctor for this condition

Group number	Social Security number

Waiver (refusal of coverage) IL-80124-SG

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 coverage for (check all that apply):

❑ 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

❑ Short-term Income Protection for: ❑ Myself

I decline to apply for group coverage because of (check all that apply): ❑ 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 medical coverage and/or deny life or dental 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 _____

Spouse signature _____ Date _____
(If covered dependent)