

51-99 new business enrollment checklist

Please submit this form with sold case

Group name: _____

Humana sales representative name: _____

Complete employer group application:

- | | |
|---|--|
| <input type="checkbox"/> Your business profile | <input type="checkbox"/> Medical plan selection form |
| <input type="checkbox"/> General eligibility | <input type="checkbox"/> Dental plan selection form |
| <input type="checkbox"/> Employer agreement | <input type="checkbox"/> Life plan selection form |
| <input type="checkbox"/> Agent/producer information sign & date | <input type="checkbox"/> Vision plan selection form |

Additional employer requirements:

- ACH form/binder check for the first month's premium made payable to: **Humana Inc.**
- Humana quote for the requested effective date with sold plan circled
- Copy of current carrier's most recent billing statement

Employee enrollment application:

- All sections completed, signed and dated
- Completed waivers on all eligible employees waiving coverage
- Application or waiver from all employees currently within COBRA/state continuation period

If applications or waivers are not obtainable, the employer must submit a letter stating they understand final rates may change if COBRA/state continuation eligibles enroll for the plan within their election period.

Notes: _____

Do not cancel current coverage until you receive written notification of coverage with Humana.

Automated Clearing House (ACH) Authorization

ACH Authorization Agreement For A One-time Payment Upon New Case Installation

Your company (hereinafter "Group") hereby agrees to allow Humana to initiate payment from Group consistent with the following:

1. The ACH payment will be pulled from the financial institution and account number authorized below in the amount of an approximation of the first month's premium payment, as acknowledged by the Group.
2. Payment shall be considered made when Humana initiates the ACH payment transaction from your company's financial institution upon completion of Group setup. If for some reason this payment is unable to be drafted, you will be contacted to authorize a new payment.
3. The initial ACH payment may be terminated by the Group by providing notification to the Sales Office prior to completion of Group setup. If notification is not received until after Group setup has been completed, a refund will be processed.

Group Information

Employer Legal Business Name		
Street Address		
City	State	Zip Code

Financial Institution Information

Name of Group's Financial Institution	Amount \$ (if left blank, the first month's premium will be debited)	
Street Address		
City	State	Zip Code
Nine-digit American Banker's Association (ABA) Identifying Number for Routing the Transfer of Funds		

Account Name
<i>Name on the account must match name of Group with which Humana is doing business.</i>
Account Number

ACH Authorization Agreement For Recurring Premium Payment

Accounts set up for a Recurring Payment will have the 'Total Amount Due' for an invoice charged to the selected account each month on the Scheduled Date. Monthly charges for the 'Total Amount Due' will continue indefinitely until cancelled.

Recurring Payment Schedule

By checking you agree to the Recurring Payment Schedule defined below.

Amount: 'Total Amount Due' from invoice. Amount can be verified on invoice or online at Humana.com.

Payment Date: Day _____ of every month. Date elected must be between 1st and 10th.

Effective Period (select one): Until Cancelled

Invoice Format (select one): Paper Electronic (will waive any applicable administrative fees)

Group is responsible for management of the Recurring Payment Schedule by registering at Humana.com or by contacting their designated billing representative.

Signature

Group's Authorizing Official: By signing this document, you authorize Humana to initiate an ACH payment(s) from the above company as requested by the Group. This includes authorization for a one-time payment upon new case installation, and/or recurring payment(s) as requested in the Recurring Payment Schedule above.

In addition, you are agreeing that the account information you have provided will be stored securely in Humana's system for future use at the discretion of the account holder for one-time payments or as scheduled for recurring payments.

Signature	Date
Printed Name	Phone number
Title	E-mail address

Employer Group Application

**ILLINOIS
HUMANA / HUMANADENTAL / COMPBENEFITS**

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 or Prepaid Dental plans)
 Immediately following waiting period
On all plans, the employee termination date coincides with the effective date provision.

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.
- Providing incomplete, inaccurate, or untimely information may void, reduce, or increase past premium, or terminate an individual's coverage or the 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.

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: _____
(month, date, year)

By: _____
(employer signature)

Dated at: _____
(city and state)

By: _____
(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: <input type="radio"/> No <input type="radio"/> Yes If yes, percentage: (total should equal 100%)	Percentage of sales: <input type="radio"/> No <input type="radio"/> Yes 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: <input type="radio"/> No <input type="radio"/> Yes If yes, percentage: (total should equal 100%)	Percentage of sales: <input type="radio"/> No <input type="radio"/> Yes 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/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, unless otherwise provided under the state law. 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 with authority to make claim determinations as described in Section 503 of ERISA, we may make decisions under the Policy or Group Plan with respect to determining eligibility for coverage and paying claims for benefits, including deciding appeals of denied claims.

You understand and agree that failure to remit and pay premium when due will be considered a default in premium payment, and that coverage will be terminated by us, following a grace period of 31 days from the date of non-payment of premium. 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 six 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.

The following applies to medical products insured by Humana Insurance Company

You, the participating employer, apply to participate in the Employers Health Insurance Benefits Trust (No. 1 and/or No. 3) for insurance coverage, which may be modified from time to time, as underwritten by us.

If you are accepted, you acknowledge and agree on behalf of all persons who obtain insurance coverage through or under your application to the Trust, that the Trust Agreement, the provisions of the Trust, or any other written instrument the trustee signs on behalf of the Trust are fully binding upon you. The principal duties of the trustee are to hold the insurance policy(ies) through which insurance coverage is provided for employers in accordance with the terms of

the Trust Agreement or any other written instrument which the trustee signs on behalf of the Trust.

The Trust Agreement, any other written instrument and the insurance policy(ies), are available for inspection by you or by any covered person through or under your participation in the Trust, during normal business hours at our home office. You further understand and agree that the Trust and Trustee are not insurers. You may withdraw from the Trust at any time subject to certain premium obligations described in the Employer Agreement section, thus terminating your insurance coverage, provided written notice of termination is received by us prior to the requested termination date.

HUMANA[®]
Guidance when you need it most

HMO plans offered by Humana Health Plan, Inc. PPO, Classic medical plans, Life and Short-Term Income Protection plans insured or administered by Humana Insurance Company.

HUMANA[®]
Specialty Benefits

Dental PPO and Traditional Preferred plans insured or administered by HumanaDental Insurance Company or Humana Insurance Company. Dental prepaid plans and AdvantagePlus dental plans offered and administered by CompBenefits Dental, Inc. CompBenefits Vision plan insured and administered by CompBenefits Insurance Company.

Humana Small Group Medical

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) : % _____ Non-participating (Out): % _____	Participating (In) : % _____ Non-participating (Out): % _____	Participating (In) : % _____ Non-participating (Out): % _____
Deductible (if applicable)	Participating: \$ _____ Non-participating: \$ _____	Participating: \$ _____ Non-participating: \$ _____	Participating: \$ _____ Non-participating: \$ _____
Out-of-pocket limit (if applicable)	Participating: \$ _____ Non-participating: \$ _____	Participating: \$ _____ Non-participating: \$ _____	Participating: \$ _____ Non-participating: \$ _____
Network name (if applicable)			

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

	Plan 1	Plan 2	Plan 3
Supplemental Accident	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> 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:	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> 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 50 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 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 _____%

Do you wish to have 24-hour coverage for employees not covered by Workers' Compensation? No Yes
If yes, name(s): _____

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

Group Information (continued)

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: \$ _____	Employee: \$ _____ Spouse: \$ _____
Child(ren): \$ _____ Family: \$ _____	Child(ren): \$ _____ Family: \$ _____
Plan design: _____	Plan design: _____
Office visit copay: _____	Office visit copay: _____
Per confinement copay: _____	Per confinement copay: _____
Deductible: • Participating _____ • Non-participating _____	Deductible: • Participating _____ • Non-participating _____
Out-of-pocket: • Participating _____ • Non-participating _____	Out-of-pocket: • Participating _____ • Non-participating _____
Coinsurance stoploss: • Participating _____ • Non-participating _____	Coinsurance stoploss: • Participating _____ • 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? <input type="radio"/> No <input type="radio"/> Yes 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? <input type="radio"/> No <input type="radio"/> Yes 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. Employee (): \$ _____ Spouse (): \$ _____ Child(ren) (): \$ _____ Family (): \$ _____	Renewal rates: In the parentheses, please indicate the number of employees enrolled in each tier, if available. Employee (): \$ _____ Spouse (): \$ _____ Child(ren) (): \$ _____ Family (): \$ _____

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:

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."

Plan Selection

Is this a SmartSuite selection? No Yes

	Plan 1	Plan 2
Plan Name (as shown on your proposal)		
Coinsurance:	Participating (In) : % ____/____/____ Non-participating (Out): % ____/____/____	Participating (In) : % ____/____/____ Non-participating (Out): % ____/____/____
Deductible:	Participating (In): \$ Non-participating (Out): \$	Participating (In): \$ Non-participating (Out): \$
Annual Maximum:	\$	\$
Preventive Services Deductible Options:	<input type="radio"/> Apply Deductible <input type="radio"/> Waive Deductible	<input type="radio"/> Apply Deductible <input type="radio"/> Waive Deductible
Periodontic/Endodontic Options:	<input type="radio"/> Basic <input type="radio"/> Major	<input type="radio"/> Basic <input type="radio"/> Major
Orthodontia Options:	<input type="radio"/> Child Only: Lifetime Orthodontia Maximum \$ _____ <input type="radio"/> Adult And Child: Lifetime Orthodontia Maximum \$ _____	
Composite Fillings for Molars:	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
Implant Coverage:	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
Out of network reimbursement options:	<input type="radio"/> Maximum allowable fee <input type="radio"/> In-network fee schedule	
Open Enrollment:	<input type="radio"/> No <input type="radio"/> Yes	

Underwriting Requirements

- Underwriting approval is required to offer more than one dental carrier to your employees.
- Dental 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.
- Minimum employer contribution toward employee premium is 25%. This minimum does not apply to Voluntary coverage.
- 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 and must be at least 50 for 51+ enrolled employees.
- Excluded class options: hourly, salary, union, non-union, management, non-management.
- If you do not maintain eligibility, underwriting, and participation requirements, we will terminate your coverage.

Participation requirements:

Eligible Employees	Participation
2+ (Employer Pays 100% of Premium)	100%
2+ (Employees Contribute to Premium)	75%
2+ Eligible Employees with Spousal Waiver	50%

Voluntary Participation Requirements:

Eligible Employees	Participation
Traditional Preferred, PPO, Preventive Plus	
2+ Employees	Two enrolled employees or 25% whichever is greater.
Advantage Plus	
10+ Employees	Ten enrolled employees or 25% whichever is greater
Prepaid	
2+ Employees	Two or more enrolled employees
Prepaid with orthodontia coverage	
10 + employees	Ten or more employees

Group Information

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

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

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

Did your prior dental coverage include orthodontia? No Yes

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

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."

Plan Selection

Basic Employee Life and Accidental Death and Dismemberment

- Flat Amount—indicate level: \$ _____
- Salary Plan—options are 1x to 6x salary, rounded to the next highest \$1,000. Indicate salary level: _____ x Salary
- Position Schedule—classifications cannot exceed 2.5 times between each class and 10 times between the lowest and highest class.

Class	Description	Benefit Amount / Salary Factor
I	_____	_____
II	_____	_____
III	_____	_____
IV	_____	_____

Basic Dependent Life: No Yes
If yes: \$10,000/\$5,000 \$5,000/\$2,500
Available only to employees enrolled for Basic Life.

Voluntary Employee Life: No Yes
If yes: AD&D No Yes

Voluntary Dependent Life: No Yes
Available only to employees enrolled for Voluntary Life.

Portability of coverage:
Groups 2-99: Included
Groups 100+: No Yes

Underwriting Requirements

- Basic Life coverage is available to employers with two or more enrolled employees.
- Voluntary life coverage is available to employers with five 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.
- Minimum employer contribution toward employee premium is 50%. This minimum does not apply to voluntary coverage.
- Retirees are not eligible for life coverage.
- Excluded class options: hourly, salary, union, non-union, management, non-management.
- If you do not maintain eligibility, underwriting, and participation requirements, we will terminate your coverage.

Basic Term Life participation

- Non-contributory plans—100%
- Contributory plans—75%
- Single medical carrier: You must have 100% participation of all eligible employees for this coverage, regardless of whether they have medical coverage through their spouse for non-contributory plans. For contributory plans, 75% participation required; minimum employer contribution 50%.
- Multiple medical carrier: If you offer more than one medical carrier, you must enroll 100% of those employees who take our coverage regardless of the percentage of contribution paid by you.

Voluntary Term Life participation

- Five employees or 25%, whichever is greater.

Group Information

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

Thank you for choosing Humana.

Please refer to your proposal to complete this information. This document will form part of any contract issued.

Plan Selection

	Plan 1	Plan 2
Plan Name (as shown on your proposal)		
Open Enrollment:	<input type="radio"/> No <input type="radio"/> Yes	

Group Information

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

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

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

Thank you for choosing Humana.

Humana Employee Enrollment Application - 51-99 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, and Traditional Preferred 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 and AdvantagePlus dental plans offered and administered by CompBenefits Dental, Inc. CompBenefits Vision plan insured and administered by CompBenefits Insurance Company.

Please print clearly and fill in each applicable circle.

Medical Group number	Benefit number	Division
Company name	Proposed Effective Date __/__/____	
Company city	State	

Employee Information

IL-80124-GN 12/2007

Last name	First name	MI	Date of birth __/__/____
Social Security number	Phone number		
Gender: <input type="radio"/> Female <input type="radio"/> Male	Email address		
Street address	Apt / Suite / PO Box number		
City	State	Zip code	County
Language of choice: <input type="radio"/> English <input type="radio"/> Spanish			
Employment status: Number of hours worked per week	Date of full-time hire __/__/____	<input type="radio"/> Full-time employee	<input type="radio"/> Retiree
Are you disabled or unable to perform normal activities? <input type="radio"/> No <input type="radio"/> Yes If yes, indicate reason:			

Dependent Information

IL-80124-DP 12/2007

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: <input type="radio"/> Female <input type="radio"/> Male	Relationship: <input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other:	
Dependent status (if applicable): <input type="radio"/> Full-time student <input type="radio"/> Disabled	If disabled, indicate reason:		
HMO only:			
Primary care physician	Physician ID	Current Patient: <input type="radio"/> No <input type="radio"/> Yes	
Prepaid Only: Dentist name			
Current Patient: <input type="radio"/> No <input type="radio"/> Yes			

2. Last name	First name	MI	Date of birth __/__/____
Social Security number	Gender: <input type="radio"/> Female <input type="radio"/> Male	Relationship: <input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other:	
Dependent status (if applicable): <input type="radio"/> Full-time student <input type="radio"/> Disabled	If disabled, indicate reason:		
HMO only:			
Primary care physician	Physician ID	Current Patient: <input type="radio"/> No <input type="radio"/> Yes	
Prepaid Only: Dentist name			
Current Patient: <input type="radio"/> No <input type="radio"/> Yes			

3. Last name	First name	MI	Date of birth __/__/____
Social Security number	Gender: <input type="radio"/> Female <input type="radio"/> Male	Relationship: <input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other:	
Dependent status (if applicable): <input type="radio"/> Full-time student <input type="radio"/> Disabled	If disabled, indicate reason:		
HMO only:			
Primary care physician	Physician ID	Current Patient: <input type="radio"/> No <input type="radio"/> Yes	
Prepaid Only: Dentist name			
Current Patient: <input type="radio"/> No <input type="radio"/> Yes			

Group Number

Social Security Number

Medical IL-80124-MD 12/2007

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

Plan name Network name

HMO only:
Employee primary care physician Physician ID Current Patient: No Yes

Concurrent medical coverage:

• Will you or any of your covered dependents have any other individual or other group medical coverage, including Medicare, in effect at the same time as this Humana coverage? No Yes
If yes, please complete below.

Individual or other group medical coverage:

Medical carrier name

Policy number Effective date __/__/____

Carrier phone number Term date __/__/____

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

Medicare coverage:

Employee Coverage: No Yes Effective date __/__/____

Medicare ID Term date __/__/____

Spouse Coverage: No Yes Effective date __/__/____

Medicare ID Term date __/__/____

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

• Within the past 12 months, have you or any of your covered dependents had any other individual or other group medical coverage, including Medicare? No Yes If yes, please complete below.

Individual or other group medical coverage:

Prior medical carrier name

Prior Policy number Effective date __/__/____

Prior carrier phone number Term date __/__/____

Prior coverage type: Employee only Employee and spouse
 Employee and child(ren) Family

Medicare coverage:

Prior Employee Coverage: No Yes Effective date __/__/____

Prior Medicare ID Term date __/__/____

Prior Spouse Coverage: No Yes Effective date __/__/____

Prior Medicare ID Term date __/__/____

Dental IL-80124-HD 12/2007

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 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 and spouse Employee and child(ren) Family

Basic Life IL-80124-BL 12/2007

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 IL-80124-VL 12/2007

Group number Benefit number Class/Division

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) \$

Vision IL-80124-VS 12/2007

Group number Benefit number Class/Division

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

Plan name

Group Number

Social Security Number

Short-term Income Protection IL-80124-SP 12/2007

Group number _____ Benefit number _____ Class/Division _____
Do you elect short-term income protection coverage? No Yes Annual salary \$ _____

Class (employer will provide if needed)

Medical Health History IL-80124-MH 12/2007

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

1. Within the past 24 months have you or any dependent had or been treated for an illness or injury or had surgery or hospitalization recommended? No Yes
2. Within the past 24 months have you or any dependent been prescribed medication? No Yes
3. Are you or any dependent currently pregnant? No Yes; Incurred medical expenses in excess of \$7,500 in the past 12 months? 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 _____
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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 ___/___/____

Agreement IL-80124-AA 12/2007

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.
- If you decide not to sign this authorization, Humana can not complete your plan enrollment or determine your premium rate due to the inability to obtain the necessary information.
- If selecting the Health Savings Account (HSA), you authorize Humana or our banking partners to provide your account number to your employer for the purposes of depositing any contributions.
- 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, 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 group coverage

Employee or legal representative signature: _____ Date: _____

Name and relationship of legal representative: _____