

Use the following alternate address for these dependents: 1 2 3 4

Street address

[Grid for street address]

Apt / Suite / PO box number

[Grid for apt/suite/PO box number]

City

[Grid for city]

State

[Grid for state]

Zip code

[Grid for zip code]

County

[Grid for county]

Medical

- Coverage type: Employee // Individual only
- Employee // Individual & spouse
- Employee // Individual & child(ren)
- Family
- Other

Office use only

Group #

[Grid for group #]

Benefit #

[Grid for benefit #]

Class/Div #

[Grid for class/div #]

Plan name

[Grid for plan name]

Network name

[Grid for network name]

Do you or any covered dependent(s) currently have other medical coverage, such as a spouse's plan, another Humana medical plan, or Medicare? Yes No If yes, list all: (This section must be completed for Humana to process any medical claims.)

Medicare ID or medical carrier name:

[Grid for Medicare ID or medical carrier name]

Starting date (MM/DD/YYYY)

[Grid for starting date]

Coverage Type

(check all that apply)

- Employee / Individual
- Spouse
- Child(ren)

End date, if applicable (MM/DD/YYYY)

[Grid for end date]

Medicare ID or medical carrier name:

[Grid for Medicare ID or medical carrier name]

Starting date (MM/DD/YYYY)

[Grid for starting date]

Coverage Type

(check all that apply)

- Employee / Individual
- Spouse
- Child(ren)

End date, if applicable (MM/DD/YYYY)

[Grid for end date]

Have you or any covered dependent(s) had medical insurance from a company (including another Humana plan) in the past 18 months? Yes No If yes, list all: (This section must be completed for Humana to process any medical claims.)

Prior medical carrier name:

[Grid for prior medical carrier name]

Starting date (MM/DD/YYYY)

[Grid for starting date]

Coverage Type

(check all that apply)

- Employee / Individual
- Spouse
- Child(ren)

End date, if applicable (MM/DD/YYYY)

[Grid for end date]

Prior medical carrier name:

[Grid for prior medical carrier name]

Starting date (MM/DD/YYYY)

[Grid for starting date]

Coverage Type

(check all that apply)

- Employee / Individual
- Spouse
- Child(ren)

End date, if applicable (MM/DD/YYYY)

[Grid for end date]

Medical Health History (for 51-100 groups) - Do not submit more than 90 days prior to the effective date

1. Within the past 24 months have you or any dependent to be covered had or been treated for an illness or injury, had surgery or hospitalization recommended? N Y
2. Within the past 24 months have you or any dependent to be covered been prescribed medication? N Y
3. Have you or any dependent to be covered incurred medical expenses in excess of \$7,500 in the past 12 months? N Y

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 (reorder IL-51340-MH), if necessary.

Question#

[Grid for question number]

Person Treated Last name

[Grid for person treated last name]

First Name

[Grid for first name]

Condition

[Grid for condition]

Treatments received

[Grid for treatments received]

Medications

[Grid for medications]

Current or future treatments or medications

[Grid for current or future treatments or medications]

Date diagnosed (MM/DD/YYYY)

[Grid for date diagnosed]

Date last seen by a doctor (MM/DD/YYYY)

[Grid for date last seen by a doctor]

Health Savings Account (HSA) Applicable only with High Deductible Health Plan selection

Do you elect the Health Savings Account?
 Yes No If no, complete waiver section

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

Office use only

Group #	Benefit #	Class/Div #
<input type="text"/>	<input type="text"/>	<input type="text"/>

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.

Beneficiary for this account will be the employee / individual's estate. You may change beneficiary information on file with the bank that administers the HSA once the account is established.

Flexible Spending Account (FSA)

Do you elect the flexible health account?
 Yes No If no, complete waiver section

Annual amount elected:
 \$, .00

Start date (MM/DD/YYYY)	End date (MM/DD/YYYY)
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>

Do you elect the flexible dependent health account? Yes No If no, complete waiver section

Annual amount elected:
 \$, .00

Start date (MM/DD/YYYY)	End date (MM/DD/YYYY)
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>

Office use only

Group #	Benefit #	Class/Div #
FSA HC <input type="text"/>	<input type="text"/>	<input type="text"/>

Office use only

Group #	Benefit #	Class/Div #
FSA DC <input type="text"/>	<input type="text"/>	<input type="text"/>

Dental

Coverage type: Employee / Individual only
 Employee / Individual & spouse
 Employee / Individual & child(ren)
 Family
 Other

Office use only

Group #	Benefit #	Class/Div #
<input type="text"/>	<input type="text"/>	<input type="text"/>

Plan name

Within the past 12 months, have you or any covered family individual had any dental or orthodontia coverage, such as a spouse's dental coverage? Yes No If yes, list all: (This section must be completed for Humana to process any dental claims)

Current dental carrier name:	Orthodontia coverage?	Starting date (MM/DD/YYYY)	End date, if applicable (MM/DD/YYYY)
<input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>

Coverage Type (check all that apply) Employee / Individual Spouse Child(ren)

Prior dental carrier name:	Orthodontia coverage?	Starting date (MM/DD/YYYY)	End date, if applicable (MM/DD/YYYY)
<input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>

Coverage type check all that apply) Employee / Individual only Employee / Individual and spouse Employee / Individual and child(ren) Family

DHMO	Employee primary care dentist name <input type="text"/>	Dentist ID # <input type="text"/>	Current patient? <input type="radio"/> Yes <input type="radio"/> No
1 DHMO	Dependent primary care dentist name <input type="text"/>	Dentist ID # <input type="text"/>	Current patient? <input type="radio"/> Yes <input type="radio"/> No
2 DHMO	<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No
3 DHMO	<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No

Basic Life / AD&D

Do you elect basic employee / individual life coverage?
 Yes No If no, complete waiver section

Office use only

Group #	Benefit #	Class/Div #
<input type="text"/>	<input type="text"/>	<input type="text"/>

Class (employer / group will provide you with this information if needed)

Do you elect basic dependent life? Yes No If no, complete waiver section

Voluntary Life / AD&D

Do you elect voluntary employee / individual life coverage?

Yes No If no, complete waiver section

If yes, amount elected (minimum of \$15,000):

\$, .00

Office use only

Group #	Benefit #	Class/Div #
<input type="text"/>	<input type="text"/>	<input type="text"/>

Voluntary dependent life selection (available only if employee / individual elects voluntary life coverage):

Do you elect voluntary spouse life coverage? Yes No If no, complete waiver section

If yes, voluntary spouse life coverage (minimum of \$5,000): \$, .00

Do you elect voluntary child(ren) life coverage? Yes No If no, complete waiver section

Vision

Coverage type: Employee / Individual only
 Employee / Individual & spouse
 Employee / Individual & child(ren)
 Family
 Other

Office use only

Group #	Benefit #	Class/Div #
<input type="text"/>	<input type="text"/>	<input type="text"/>

Plan name

Short Term Disability

Do you elect short term disability coverage?

Yes No If no, complete waiver section

Buy-up percent/amount _____

Office use only

Group #	Benefit #	Class #	Div #
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Long Term Disability

Do you elect long term disability coverage?

Yes No If no, complete waiver section

Buy-up percent/amount _____

Office use only

Group #	Benefit #	Class #	Div #
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Group Term Life / AD&D

Office use only Group # Benefit # Class # Div #

	Coverage requested for (check all that apply)	Coverage requested (complete only if plan provides a choice of benefit schedules)	Cost per pay period	
Employee / Individual	<input type="radio"/> Basic Term Life	_____	\$	<input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> .00
	<input type="radio"/> Supplemental Term Life*	_____	\$	<input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> .00
	<input type="radio"/> Basic AD&D	_____	\$	<input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> .00
	<input type="radio"/> Supplemental AD&D	_____	\$	<input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> .00
Spouse	<input type="radio"/> Basic Term Life	_____	\$	<input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> .00
	<input type="radio"/> Supplemental Term Life*	_____	\$	<input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> .00
	<input type="radio"/> Basic AD&D	_____	\$	<input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> .00
	<input type="radio"/> Supplemental AD&D	_____	\$	<input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> .00
Child(ren)	<input type="radio"/> Basic Term Life	_____	\$	<input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> .00
	<input type="radio"/> Supplemental Term Life*	_____	\$	<input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> .00
	<input type="radio"/> Basic AD&D	_____	\$	<input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> .00
	<input type="radio"/> Supplemental AD&D	_____	\$	<input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> .00

*Complete Evidence of Insurability form if selecting one of these benefit amounts.

Workplace Voluntary Benefits: Optional riders availability based on employer / group election.

Accident - 2012

Office use only Group # Benefit # Class # Div #

Accident N Y Benefit Level: 1 2 3 4

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

Disability Income Plus

Office use only Group # Benefit # Class # Div #

- Disability Income Covering Accident and Sickness N Y
 - Base Benefit Period: 3 Month 6 Month 1 Year 2 Year 3 Year
 - Base Elimination Period: 0/7 7/7 0/14 14/14 30/30 60/60 90/90
 - 180/180 365/365
- Disability Income Covering Accident and Sickness with Waiver of Elimination Period N Y Monthly benefit
 - Base Benefit Period: 3 Month 6 Month 1 Year 2 Year 3 Year \$, .00
 - Base Elimination Period: 0/7 7/7 0/14 14/14
 - Optional Disability Income Benefits: ICU/CCU Benefit \$200 \$400 \$600 \$800
 - Physical Therapy Benefit
 - COBRA Rider COBRA monthly benefit \$, .00

Level Term Life

Office use only Group # Benefit # Class # Div #

- Level Term Life N Y Coverage type: Employee / Individual only Spouse Child(ren) No Coverage
- Base Plan: 10 Year Term 20 Year Term
- Optional Benefit: Automatic Benefit Increase

Employee / Individual Benefit \$, .00 Spouse Benefit \$, .00 Child(ren) Benefit \$, .00

If your employer or group has elected the critical illness rider, does anyone on this application have a parent, brother, or sister with a history of heart attack, heart disease, stroke, or cancer diagnosis prior to age 60? N Y

If yes, please indicate whether this applies to you (employee / individual), your spouse or a dependent.

You (employee / individual) Spouse Dependent Name _____

Evidence of Health Status (continued)

6.	Has anyone on this application been advised by a member of the medical profession to have any diagnostic test, hospitalization, or surgery that has not been completed within the past 5 years?	<input type="radio"/> N <input type="radio"/> Y
7.	Within the past 5 years, has anyone on this application seen a health care provider or specialist for a routine physical/wellness exam, or been seen for any reason not previously disclosed?	<input type="radio"/> N <input type="radio"/> Y
8.	Hospital Indemnity only: Can you perform your activities of daily living (ADL's) without need of assistance? ADL's include: Bathing, Transferring, Feeding, Dressing and Bowl/Bladder/Toileting	<input type="radio"/> N <input type="radio"/> Y

<input type="radio"/> Employee last name	First Name	MI	Height (ft/in)	Weight (lbs)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="radio"/> Dependent 1 last name	First Name	MI	Height (ft/in)	Weight (lbs)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="radio"/> Dependent 2 last name	First Name	MI	Height (ft/in)	Weight (lbs)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="radio"/> Dependent 3 last name	First Name	MI	Height (ft/in)	Weight (lbs)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="radio"/> Dependent 4 last name	First Name	MI	Height (ft/in)	Weight (lbs)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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 (reorder IL-51340-MH), if necessary.

Question#	Person Treated Last name	First Name
<input type="text"/>	<input type="text"/>	<input type="text"/>
Condition		Treatments received
<input type="text"/>		<input type="text"/>
<input type="text"/>		<input type="text"/>
Medications		Current or future treatments or medications
<input type="text"/>		<input type="text"/>
<input type="text"/>		<input type="text"/>
Date diagnosed (MM/DD/YYYY)	Date last seen by a doctor (MM/DD/YYYY)	
<input type="text"/>	<input type="text"/>	

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 / group. I proclaim that I was not pressured or forced by my employer / group, 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.

<p>I hereby waive coverage for (check all that apply):</p> <p>Medical for: <input type="radio"/> Myself <input type="radio"/> My spouse <input type="radio"/> My dependent child(ren)</p> <p>Dental for: <input type="radio"/> Myself <input type="radio"/> My spouse <input type="radio"/> My dependent child(ren)</p> <p>Basic Life for: <input type="radio"/> Myself <input type="radio"/> My spouse <input type="radio"/> My dependent child(ren)</p> <p>Vision for: <input type="radio"/> Myself <input type="radio"/> My spouse <input type="radio"/> My dependent child(ren)</p> <p>Short Term Disability for: <input type="radio"/> Myself</p> <p>Long Term Disability for: <input type="radio"/> Myself</p> <p>Health Savings Account for: <input type="radio"/> Myself</p> <p>Flexible Health Account for: <input type="radio"/> Myself</p> <p>Flexible Dependent Care Account for: <input type="radio"/> Myself</p> <p>Waive Coverage for Workplace Voluntary Benefits:</p> <p>Level Term Life for: <input type="radio"/> Myself <input type="radio"/> My spouse <input type="radio"/> My dependent child(ren)</p> <p>Critical Illness for: <input type="radio"/> Myself <input type="radio"/> My spouse <input type="radio"/> My dependent child(ren)</p> <p>Group Lump Sum Cancer for: <input type="radio"/> Myself <input type="radio"/> My spouse <input type="radio"/> My dependent child(ren)</p> <p>Supplemental Health for: <input type="radio"/> Myself <input type="radio"/> My spouse <input type="radio"/> My dependent child(ren)</p> <p>Accident for: <input type="radio"/> Myself <input type="radio"/> My spouse <input type="radio"/> My dependent child(ren)</p> <p>Hospital Indemnity for: <input type="radio"/> Myself <input type="radio"/> My spouse <input type="radio"/> My dependent child(ren)</p> <p>Disability Income Plus for: <input type="radio"/> Myself</p>	<p>I decline to apply for group coverage because of:</p> <p><input type="radio"/> Spousal coverage</p> <p><input type="radio"/> Medicare supplement</p> <p><input type="radio"/> Individual coverage</p> <p><input type="radio"/> Coverage under another carrier's plan provided by my employer / group</p> <p><input type="radio"/> Other: _____</p>
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True and complete acknowledgment

I understand, agree, and represent:

- I have read the Large Group 51+ Employee Application and Enrollment Form 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 / group 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 the Large Group 51+ Employee Application and Enrollment Form for coverage is accepted, coverage will be effective on the date specified by Humana on the policy or certificate.
- 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 within 31 days after the qualifying event.
- If I or my dependents become eligible for premium or rate subsidies under Medicaid or the Children's Health Insurance Program (CHIP), I may in the future be able to enroll myself or my dependents provided I request enrollment within 60 days after the qualifying event.
- In the event that I should decide to apply for coverage hereafter, that subsequent Large Group 51+ Employee Application and Enrollment Form shall be subject to the applicable terms and conditions of the master group contract(s), policy provisions or certificate provisions which may require additional limitations and waiting periods.
- Based on the coverage I have elected, I may be required to furnish evidence of health status satisfactory to Humana.
- If I am declining coverage for myself or my dependents (including my spouse) because of coverage under Medicaid or CHIP, I may in the future be able to enroll myself or my dependents provided that I request enrollment within 60 days after my coverage under these programs ends.
- If I am declining coverage for myself or my dependents (including my spouse) because of other coverage, I may in the future be able to enroll myself or my dependents provided that I request enrollment within 31 days after my other coverage ends.
- Humana reserves the right to delay medical coverage and/or deny life or dental coverage with any future submissions of the Large Group 51+ Employee Application and Enrollment Form for coverage.
- If any deductions are required for this coverage, I authorize those deductions from my earnings. If selecting the Health Savings Account (HSA), I authorize Humana or its banking partners to provide my account number to my employer / group for the purposes of depositing any contributions.
- If I am applying for coverage for my dependents (including my spouse) I attest by my signature below, I have gathered the necessary health information from my dependents in order to fully and truthfully complete the Large Group 51+ Employee Application and Enrollment Form.
- If I have selected workplace voluntary benefits, and if coverage is not issued as initially applied for, I hereby authorize Humana to decrease or increase the premium or rate amount stated on the Large Group 51+ Employee Application and Enrollment Form to cover the benefit actually issued.
- An act of fraud or an intentional misrepresentation of a material fact may void or terminate an individual's or group's coverage as specified under the terms of the Policy or Certificate. Providing incomplete, inaccurate, or untimely information may reduce an individual's or group's coverage or may increase past premium.
- Rates or premium quoted and the effective date requested are not guaranteed. The final rate or premium and effective date will be determined upon underwriting review and approval of the Large Group 51+ Employee Application and Enrollment Form by Humana.
- Any person who willingly and knowingly submits the Large Group 51+ Employee Application and Enrollment Form containing a false, incomplete or deceptive statement may be guilty of insurance fraud.

If you decide not to sign this agreement, we will decline to enroll you in an insurance product or to give you insurance benefits.

Authorization

My dependents and I understand and agree:

- The information obtained by use of this authorization may be used by Humana to make claims determinations, determine eligibility for coverage, eligibility for benefits under an existing policy and plan administration.
- Any information obtained will not be released by Humana to any person or organization except to reinsuring companies, the Medical Information Bureau, Inc. or other persons or organizations performing health care operations or business or legal services in connection with the Large Group 51+ Employee Application and Enrollment Form, claim or as may be otherwise lawfully required, or as I (we) may further authorize.

Authorization for Release of Medical Records for Life or Disability

If my dependents or I have selected life or disability, I authorize any third party to have information regarding myself. This includes any medical or non-medical information and to share any and all such information with Humana, its reinsurer or its legal representatives, and its affiliates. 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.

The Large Group 51+ Employee Application and Enrollment Form, together with any supplemental forms, will make up part of any contract and be the basis for any policy or certificate.

Signature - Please sign below if enrolling or waiving any group coverage

Employee / Individual or legal representative signature

Date

 / /

Name and relationship of legal representative
(if a covered dependent)

Agent / Producer Information

If applying for workplace voluntary benefits, this section to be completed by Agent or Producer.

1. Agent / Agency of Record:	2. Agent / Agency of Record:
Name (print)	Name (print)
Humana Agent #	Humana Agent #
Commission split:	Commission split:
1. Writing Agent / Producer:	2. Writing Agent / Producer:
Name (print)	Name (print)
Humana Agent #	Humana Agent #
Commission split:	Commission split:

Will the coverage selected replace or change any existing life or disability insurance policy(s) and/or annuity(s)? N Y

As the Writing Agent / Producer, I acknowledge that I am responsible to meet with the primary applicant submitting the Large Group 51+ Employee Application and Enrollment Form 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 primary applicant in the benefit summary document or other plan literature.

Signed at _____
County

_____ State

Writing Agent's Signature _____

Date ___ / ___ / ___

The original version of this Agreement is in the English language. If there are any discrepancies or conflicts between the English and any other version that has been translated into another language, the English version will control.

Additional Details to Medical Questions

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

Please print clearly.

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 __ / __ / ____

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 __ / __ / ____

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 __ / __ / ____

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 __ / __ / ____

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 __ / __ / ____

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 __ / __ / ____

Employee signature _____ Date __ / __ / ____

Spouse signature (if covered dependent) _____ Date __ / __ / ____

Child signature (if covered dependent over the legal age) _____ Date __ / __ / ____

Child signature (if covered dependent over the legal age) _____ Date __ / __ / ____

Child signature (if covered dependent over the legal age) _____ Date __ / __ / ____

Life plans insured or administered by **Humana Insurance Company**. Workplace Voluntary Benefits plans insured or administered by **Kanawha Insurance Company**.

Discrimination is Against the Law

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Humana Inc. and its subsidiaries do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Humana Inc. and its subsidiaries provide:

- Free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.
- Free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as translated documents or oral interpretation.

If you need these services, call 1-877-320-1235, or if you use a TTY, call 711.

If you believe that Humana Inc. and its subsidiaries have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Discrimination Grievances
P.O. Box 14618
Lexington, KY 40512-4618

If you need help filing a grievance, call 1-877-320-1235 or if you use a TTY, call 711.

You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>**, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at **<http://www.hhs.gov/ocr/office/file/index.html>**

Multi-Language Interpreter Services

English: ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-877-320-1235 (TTY: 711).

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-320-1235 (TTY: 711).

繁體中文 (Chinese): 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-320-1235 (TTY: 711)。

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-320-1235 (TTY: 711).

한국어 (Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-320-1235 (TTY: 711)번으로 전화해 주십시오.

Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-320-1235 (TTY: 711).

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-320-1235 (телетайп: 711).

Kreyòl Ayisyen (French Creole): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-320-1235 (TTY: 711).

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-320-1235 (ATS : 711).

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-320-1235 (TTY: 711).

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-877-320-1235 (TTY: 711).

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-320-1235 (TTY: 711).

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-320-1235 (TTY: 711).

العربية (Arabic):

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-320-1235 (رقم هاتف الصم والبكم: 711).

日本語 (Japanese): 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-877-320-1235 (TTY: 711) まで、お電話にてご連絡ください。

فارسی (Farsi):

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-877-320-1235 (TTY: 711) تماس بگیرید.

Diné Bizaad (Navajo): Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hóló, kojí' hódíílnih 1-877-320-1235 (TTY: 711).