Print Form

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

Humana Employee Enrollment Form - 2-50 Employees KENTUCKY

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

Humana Health Plan, Inc., 321 West Main Street, Louisville, KY 40202 • **Humana Insurance Company of Kentucky,** 500 West Main Street, Louisville, KY 40202 • **The Dental Concern, Inc.,** 500 West Main Street, Louisville, KY 40202 • **CompBenefits Dental, Inc.**, 100 Mansell Court East, Suite 400, Roswell, GA 30076

For PPO, HMO, or POS Medical plans, coverage is provided by Humana Health Plan, Inc., a Health Maintenance Organization. For Classic Medical plans and Standard Indemnity medical plans, Life and Short-Term Income Protection plans, insurance coverage is provided or administered by Humana Insurance Company of Kentucky. For Dental, insurance coverage is provided or administered by The Dental Concern, Inc. For Dental, insurance coverage is provided or administered by CompBenefits Dental, Inc. Vision plans insured or administered by Humana Insurance Company of Kentucky or The Dental Concern, Inc.

Please print clearly and fill in each applicable circle.

Proposed effective date: _ _ / _ _ / _ _ _ _

Company name	Company city	State

Enrollment Information

Relationship	Last name, First name MI	Height (ft / in)	Weight (lbs.)	Gender	Full-time student?	Date of birth	Disabled? If yes, indicate reason.
Employee		/		❍ F ❍ M	N/A	_ _ / _ _ / _ _ _ _	❍ N ❍ Y Reason:
Spouse		/		❍ F ❍ M	N/A	_ _ / _ _ / _ _ _ _	❍ N ❍ Y Reason:
Child		/		❍ F ❍ M	❍ N ❍ Y	_ _ / _ _ / _ _ _ _	❍ N ❍ Y Reason:
Child		/		❍ F ❍ M	❍ N ❍ Y	_ _ / _ _ / _ _ _ _	❍ N ❍ Y Reason:
Child		/		❍ F ❍ M	❍ N ❍ Y	_ _ / _ _ / _ _ _ _	❍ N ❍ Y Reason:
Other (specify):		/		❍ F ❍ M	❍ N ❍ Y	_ _ / _ _ / _ _ _ _	❍ N ❍ Y Reason:

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

EMPLOYEE INFORMATION: **HOURS WORKED PER WEEK:** ❍ **RETIREE** **DATE OF FULL-TIME HIRE:** _ _ / _ _ / _ _ _ _

SSN #	Street address	APT / Suite / Box

City	State	Zip code	Phone # ( )

Language: ❍ English ❍ Spanish Email address

Medical

Group #: Benefit #: Class/Div:

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

Coverage type: ❍ Employee only ❍ Employee and spouse ❍ Employee and child(ren) ❍ Family ❍ NO COVERAGE (complete waiver) Plan name

1. Prior medical coverage during the past 18 months (individual or other group coverage)? ❍ N ❍ Y

Prior medical insurance carrier name	Policy #	**Prior coverage type:** ❍ Employee only ❍ Employee and spouse ❍ Employee and child(ren) ❍ Family	Effective date _ _ / _ _ / _ _ _ _ Term date _ _ / _ _ / _ _ _ _

2. Other medical coverage in effect at the same time as this Humana coverage (individual or other group coverage)? ❍ N ❍ Y

Other Medical Insurance carrier name	Policy #	**Other coverage type:** ❍ Employee only ❍ Employee and spouse ❍ Employee and child(ren) ❍ Family	Effective date _ _ / _ _ / _ _ _ _ Term date _ _ / _ _ / _ _ _ _

3. Medicare coverage:

Employee coverage: ❍ N ❍ Y	Medicare ID	Effective date _ _ / _ _ / _ _ _ _	Term date _ _ / _ _ / _ _ _ _
Spouse coverage: ❍ N ❍ Y	Medicare ID	Effective date _ _ / _ _ / _ _ _ _	Term date _ _ / _ _ / _ _ _ _

Last name:	First name:

Health Savings Account Group #: Benefit #: Class/Div:

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

Please refer to Humana's HSA contribution worksheet to calculate your maximum allowed contribution. You can find additional information on HSAs on Humana.com. Select the Quick Link for Spending Account information on the Member page.

Do you elect the Health Savings Account? ❍ N ❍ Y (If no, complete waiver.)	Beneficiary for this account will be the employee's estate. You may change beneficiary information on file with the bank that administers the HSA once the account is established.

Dental Group #: Benefit #: Class/Div:

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

Coverage type: ❍ Employee only ❍ Employee and spouse ❍ Employee and child(ren) ❍ Family ❍ NO COVERAGE (complete waiver)	Plan name

Prior dental coverage during the past 12 months (individual or other group coverage)? ❍ N ❍ Y

Prior dental insurance carrier name	**Prior coverage type:** ❍ Employee only ❍ Employee and spouse ❍ Employee and child(ren) ❍ Family	Effective date _ _ / _ _ / _ _ _ _	Policy #
Prior orthodontia coverage in the past 12 months? ❍ N ❍ Y		Term date _ _ / _ _ / _ _ _ _	Prior carrier phone # ( )

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

Basic Life Group #: Benefit #: Class/Div:

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

Primary beneficiary name (Last, First MI)	Secondary beneficiary name (Last, First MI)

Class (employer will provide you with this information if needed)	Annual salary (if applicable) $	**Basic dependent life?** ❍ N ❍ Y If no, complete waiver section.

Voluntary Life Group #: Benefit #: Class/Div:

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

Voluntary employee life coverage? ❍ N ❍ Y	Amount (min $15,000) $	Primary beneficiary name (Last, First MI)	Secondary beneficiary name (Last, First MI)
Voluntary spouse life coverage? ❍ N ❍ Y	Amount (min. $5,000) $	**Voluntary child(ren) life coverage?** ❍ N ❍ Y	Annual employee salary (if applicable) $

Vision Group #: Benefit #: Class/Div:

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

Coverage type: ❍ Employee only ❍ Employee and spouse ❍ Employee and child(ren) ❍ Family ❍ NO COVERAGE (complete waiver)	Plan name

Evidence of Health Status

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

Complete this section for employees and dependents enrolling for medical coverage who are members of groups with 2-50 applicants and applicants requesting Life insurance over the guarantee issue amount, and all late enrollees applying for Life coverage.

1. Are you or any dependent currently under any treatment or prescribed medications?	❍ N ❍ Y

2. Within the past 5 years, have you or any eligible dependent to be covered been diagnosed with, counseled, consulted or treated by a doctor for any of the following:

a	Coronary artery disease, chest pain, or any disease of the arteries or blood vessels; phlebitis; high blood pressure?	❍ N ❍ Y	f	Diabetes; liver or thyroid disease; or enlargement of the lymph nodes?	❍ N ❍ Y
b	Nervous, mental or emotional disorder; convulsions; epilepsy; unconsciousness?	❍ N ❍ Y	g	Stomach, gall bladder, intestinal or colon disorders?	❍ N ❍ Y
c	Asthma or other disease of lungs or respiratory organs?	❍ N ❍ Y	h	Rheumatoid arthritis or back disorders?	❍ N ❍ Y
d	Kidney stones; disease of kidney, bladder, male or female organs; or infertility?	❍ N ❍ Y	i	Paralysis, or any other physical impairment or deformity?	❍ N ❍ Y
e	Cancer, and/or cancerous tumor? (state type & part of body in details section below)	❍ N ❍ Y	j	Alcoholism or drug habit, or been a member of Alcoholics Anonymous?	❍ N ❍ Y

3. Have you or any dependent been diagnosed or received treatment for an immune system disorder (i.e. Lupus, ITP), AIDS or an AIDS-related complex?	❍ N ❍ Y
4. During the past 5 years, have you or any dependent had hospitalization or surgery scheduled or completed, had any injury, illness, medical attention or medical advice or treatment for any reason not already mentioned?	❍ N ❍ Y
5. Are you or any dependent to be covered pregnant?	❍ N ❍ Y

Last name:	First name:

Evidence of Health Status

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

Question # & letter	Person treated (Last name, First name)
Condition	Treatments received
Medications prescribed	Current or future treatments or medications
Date diagnosed _ _ / _ _ / _ _ _ _	Date last seen by a doctor _ _ / _ _ / _ _ _ _

Waiver (refusal of coverage)

I acknowledge that I have been given the opportunity to apply for group coverage available to me and my dependents through my employer. I proclaim that I was not pressured or forced by my employer, the writing agent, or Humana into waiving (declining) coverage. If I have waived any coverage offered to me or my dependents, my signature is evidence of this action.

I hereby waive coverage for (check all that apply):	I decline to apply for group coverage because of:
Medical for: ❍ Myself ❍ My spouse ❍ My dependent child(ren) Dental for: ❍ Myself ❍ My spouse ❍ My dependent child(ren) Basic Life for: ❍ Myself ❍ My spouse ❍ My dependent child(ren) Vision for: ❍ Myself ❍ My spouse ❍ My dependent child(ren) Health Savings Account for: ❍ Myself	❍ Spousal coverage ❍ Medicare supplement ❍ Individual coverage ❍ Coverage under another carrier's plan provided by my employer ❍ Other:

Agreement

True and complete acknowledgement

I understand, agree and represent:

- I have read this document or it has been read to me and answers provided are true and complete to the best of my knowledge and belief.
- Neither my employer nor the agent can waive any question, determine coverage or insurability, alter any contract or waive any of Humana's other rights and requirements.
- If this application for coverage is accepted, coverage will be effective on the date specified by Humana on the certificate of coverage/certificate of insurance. If I have a new dependent as a result of a qualifying event, I may in the future be able to enroll myself or my dependents provided I request enrollment with in 31 days after the qualifying event.
- In the event that I should decide to apply for coverage hereafter, that subsequent application shall be subject to the applicable terms and conditions of the master group contract(s) or plan provisions which may require additional limitations and waiting periods.
- I may be required to furnish, at my own expense, evidence of health status satisfactory to Humana.
- If I am declining coverage for myself or my dependents (including my spouse) because of other coverage, I may in the future be able to enroll myself or my dependents provided that I request enrollment within 31 days after my other coverage ends.
- In the event that an application is submitted outside of an open enrollment period, without a qualifying event, or by submitting an incomplete enrollment form Humana reserves the right to delay coverage.
- If any deductions are required for this coverage, I authorize those deductions from my earnings. If selecting the Health Savings Account (HSA), I authorize Humana or its banking partners to provide my account number to my employer for the purposes of depositing any contributions.
- Intentional fraud or intentional misrepresentation of a material fact may void, reduce or increase past premium, or terminate an individual's coverage or group's coverage.
- Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Authorization

I authorize Humana, its reinsurer or its legal representatives, and its affiliates to have information regarding myself–this includes any medical or non-medical information. Any information obtained will not be released by the company checked below to any person or organization except to reinsuring companies, the Medical Information Bureau, Inc. or other persons or organizations performing health care operations or business or legal services in connection with an application, claim or as may be otherwise lawfully required, or as I (we) may further authorize. Once personal and health (including medical, dental and pharmacy) information is disclosed pursuant to this authorization, the recipient may redisclose it and the information may not be protected by federal and state privacy requirements.

My dependents and I understand and agree:

- The information obtained by use of this authorization may be used by Humana to make claims determinations, determine eligibility for coverage, eligibility for benefits under an existing policy and plan administration.
- A photographic copy of this authorization shall be as valid as the original.
- This authorization shall be valid for two years from the date shown below and I have the right to revoke this authorization at any time by writing to Humana's Privacy Office.

This document, together with any supplements, will form part of any contract and be the basis for any certificate of coverage/certificate of insurance issued.

Last name:	First name:

Signature - please sign below if enrolling or waiving group coverage.

If you decide not to sign this authorization, Humana cannot complete your plan enrollment or determine your premium rate due to the inability to obtain the necessary information.

Employee or legal representative signature: _____ Date: _____

Name and relationship of legal representative: _____

Spouse signature: _____ Date: _____

(Only if selecting Life coverage over the guarantee issue amount.)

Last name: | First name:

Humana Employee Primary Care Physician/Dentist Selection — KENTUCKY

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Please print clearly and fill in each applicable circle.

Primary Care Physician/Dentist Selection

Relationship	Member Last name, First name MI	Primary care physician name	Physician ID	Current patient?	Primary dentist name	Current patient?
Employee				❍ N ❍ Y		❍ N ❍ Y
Spouse				❍ N ❍ Y		❍ N ❍ Y
Child				❍ N ❍ Y		❍ N ❍ Y
Child				❍ N ❍ Y		❍ N ❍ Y
Child				❍ N ❍ Y		❍ N ❍ Y
Other (specify):				❍ N ❍ Y		❍ N ❍ Y

Humana Employee Enrollment Form - Short-Term Income Protection (STIP) — KENTUCKY

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

Short-Term Income Protection plans insured or administered by Humana Insurance Company of Kentucky, 500 West Main Street, Louisville, KY 40202.

Please print clearly and fill in each applicable circle.

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

Short-Term Income Protection plans insured or administered by **Humana Insurance Company of Kentucky**, 500 West Main Street, Louisville, KY 40202.

Do you elect Short-Term Income Protection coverage? ❍ N ❍ Y (If no, complete waiver.)	Annual salary $	Class (employer will provide if needed)

Waiver (refusal of coverage) for STIP

I acknowledge that I have been given the opportunity to apply for group coverage available to me and my dependents through my employer. I proclaim that I was not pressured or forced by my employer, the writing agent, or Humana into waiving (declining) coverage. If I have waived any coverage offered to me or my dependents, my signature is evidence of this action.

I hereby waive coverage for (check all that apply):
Short-Term Income Protection for: ❍ Myself

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