

Humana Employee Enrollment Form - 2-50 Employees

OHIO

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 of Ohio, Inc. POS plans offered by Humana Health Plan of Ohio, Inc. and insured or administered by Humana Insurance Company. PPO and Classic medical plans and Life plans insured or administered by Humana Insurance Company. Dental plans insured or administered by HumanaDental Insurance Company, Humana Insurance Company or CompBenefits Insurance Company. CompBenefits Vision plan insured and administered by CompBenefits Insurance Company.

Please print clearly and fill in each applicable circle.

Proposed effective date: ___/___/_____

Company name	Company city	State
--------------	--------------	-------

Enrollment Information OH-72000-EI 1/2008

Relationship	Last name, First name MI	Height (ft / in)	Weight (lbs.)	Gender	Full-time student?	Date of birth	Disabled? If yes, indicate reason.
Employee		/		<input type="radio"/> F <input type="radio"/> M	N/A	___/___/_____	<input type="radio"/> N Reason: <input type="radio"/> Y
Spouse		/		<input type="radio"/> F <input type="radio"/> M	N/A	___/___/_____	<input type="radio"/> N Reason: <input type="radio"/> Y
Child		/		<input type="radio"/> F <input type="radio"/> M	<input type="radio"/> N <input type="radio"/> Y	___/___/_____	<input type="radio"/> N Reason: <input type="radio"/> Y
Child		/		<input type="radio"/> F <input type="radio"/> M	<input type="radio"/> N <input type="radio"/> Y	___/___/_____	<input type="radio"/> N Reason: <input type="radio"/> Y
Child		/		<input type="radio"/> F <input type="radio"/> M	<input type="radio"/> N <input type="radio"/> Y	___/___/_____	<input type="radio"/> N Reason: <input type="radio"/> Y
Other (specify):		/		<input type="radio"/> F <input type="radio"/> M	<input type="radio"/> N <input type="radio"/> Y	___/___/_____	<input type="radio"/> N Reason: <input type="radio"/> Y

EMPLOYEE INFORMATION:	HOURS WORKED PER WEEK:	<input type="radio"/> RETIREE	DATE OF FULL-TIME HIRE: ___/___/_____
SSN #	Street address	APT / Suite / Box	
City	State	Zip code	Phone # ()
Language: <input type="radio"/> English <input type="radio"/> Spanish		Email address	

Medical OH-72000-MD 1/2008

Group #:	Benefit #:	Class/Div:	Plan name
Coverage type: <input type="radio"/> Employee only <input type="radio"/> Employee and spouse <input type="radio"/> Employee and child(ren) <input type="radio"/> Family <input type="radio"/> NO COVERAGE (complete waiver)			
1. Prior medical coverage during the past 18 months (individual or other group coverage)? <input type="radio"/> N <input type="radio"/> Y			
Prior medical insurance carrier name	Policy #	Prior coverage type: <input type="radio"/> Employee only <input type="radio"/> Employee and spouse <input type="radio"/> Employee and child(ren) <input type="radio"/> Family	Effective date ___/___/_____ Term date ___/___/_____
2. Other medical coverage in effect at the same time as this Humana coverage (individual or other group coverage)? <input type="radio"/> N <input type="radio"/> Y			
Other Medical Insurance carrier name	Policy #	Other coverage type: <input type="radio"/> Employee only <input type="radio"/> Employee and spouse <input type="radio"/> Employee and child(ren) <input type="radio"/> Family	Effective date ___/___/_____ Term date ___/___/_____
3. Medicare coverage:			
Employee coverage: <input type="radio"/> N <input type="radio"/> Y	Medicare ID	Effective date ___/___/_____	Term date ___/___/_____
Spouse coverage: <input type="radio"/> N <input type="radio"/> Y	Medicare ID	Effective date ___/___/_____	Term date ___/___/_____

Health Savings Account OH-72000-HA 1/2008

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? <input type="radio"/> N <input type="radio"/> 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 OH-72000-HD 1/2008

Group #:	Benefit #:	Class/Div:	Plan name
Coverage type: <input type="radio"/> Employee only <input type="radio"/> Employee and spouse <input type="radio"/> Employee and child(ren) <input type="radio"/> Family <input type="radio"/> NO COVERAGE (complete waiver)			
Prior dental coverage during the past 12 months (individual or other group coverage)? <input type="radio"/> N <input type="radio"/> Y			
Prior dental insurance carrier name	Prior coverage type: <input type="radio"/> Employee only <input type="radio"/> Employee and spouse <input type="radio"/> Employee and child(ren) <input type="radio"/> Family	Effective date ___/___/_____ Term date ___/___/_____	Policy #
Prior orthodontia coverage in the past 12 months? <input type="radio"/> N <input type="radio"/> Y			Prior carrier phone # ()

Last name: _____

First name: _____

Basic Life	Group #:	Benefit #:	Class/Div:	OH-72000-BL 1/2008
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? <input type="radio"/> N <input type="radio"/> Y If no, complete waiver section.	

Voluntary Life	Group #:	Benefit #:	Class/Div:	OH-72000-VL 1/2008
Voluntary employee life coverage? <input type="radio"/> N <input type="radio"/> Y	Amount (min \$15,000) \$	Primary beneficiary name (Last, First MI)	Secondary beneficiary name (Last, First MI)	
Voluntary spouse life coverage? <input type="radio"/> N <input type="radio"/> Y	Amount (min. \$5,000) \$	Voluntary child(ren) life coverage? <input type="radio"/> N <input type="radio"/> Y	Annual employee salary (if applicable) \$	

Vision	Group #:	Benefit #:	Class/Div:	OH-72000-VS 1/2008
Coverage type: <input type="radio"/> Employee only <input type="radio"/> Employee and spouse <input type="radio"/> Employee and child(ren) <input type="radio"/> Family <input type="radio"/> NO COVERAGE (complete waiver)			Plan name	

Evidence of Health Status OH-72000-HS 1/2008

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?		<input type="radio"/> N <input type="radio"/> 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?	<input type="radio"/> N <input type="radio"/> Y
b	Nervous, mental or emotional disorder; convulsions; epilepsy; unconsciousness?	<input type="radio"/> N <input type="radio"/> Y
c	Asthma or other disease of lungs or respiratory organs?	<input type="radio"/> N <input type="radio"/> Y
d	Kidney stones; disease of kidney, bladder, male or female organs; or infertility?	<input type="radio"/> N <input type="radio"/> Y
e	Cancer, and/or cancerous tumor? (state type & part of body in details section below)	<input type="radio"/> N <input type="radio"/> Y
f	Diabetes; liver or thyroid disease; or enlargement of the lymph nodes?	<input type="radio"/> N <input type="radio"/> Y
g	Stomach, gall bladder, intestinal or colon disorders?	<input type="radio"/> N <input type="radio"/> Y
h	Rheumatoid arthritis or back disorders?	<input type="radio"/> N <input type="radio"/> Y
i	Paralysis, or any other physical impairment or deformity?	<input type="radio"/> N <input type="radio"/> Y
j	Alcoholism or drug habit, or been a member of Alcoholics Anonymous?	<input type="radio"/> N <input type="radio"/> 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?		<input type="radio"/> N <input type="radio"/> 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?		<input type="radio"/> N <input type="radio"/> Y
5. Are you or any dependent to be covered pregnant?		<input type="radio"/> N <input type="radio"/> Y

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) OH-72000-WV 1/2008

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): Medical for: <input type="radio"/> Myself <input type="radio"/> My spouse <input type="radio"/> My dependent child(ren) Dental for: <input type="radio"/> Myself <input type="radio"/> My spouse <input type="radio"/> My dependent child(ren) Basic Life for: <input type="radio"/> Myself <input type="radio"/> My spouse <input type="radio"/> My dependent child(ren) Vision for: <input type="radio"/> Myself <input type="radio"/> My spouse <input type="radio"/> My dependent child(ren) Health Savings Account for: <input type="radio"/> Myself	I decline to apply for group coverage because of: <input type="radio"/> Spousal coverage <input type="radio"/> Medicare supplement <input type="radio"/> Individual coverage <input type="radio"/> Coverage under another carrier's plan provided by my employer <input type="radio"/> Other:
--	--

Last name: _____

First name: _____

Agreement

OH-72000-AA 1/2008

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 within 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.
- Humana reserves the right to delay medical coverage and/or deny life or dental coverage with any future application 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 for the purposes of depositing any contributions.
- 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.
- Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer or health maintenance organization, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Authorization

My dependents and I authorize any third party to have information regarding myself and my dependents. 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.

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 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.
- 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.

STATE NOTICE:

Warning: If you or your family members are covered by more than one health care plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors, dentists, and hospitals, and it may be impossible to comply with both plans at the same time. Before you enroll in this plan, read all of the rules very carefully and compare them with the rules of any other plan that covers you or your family.

Notice of Cancellation: If you are obligated for any part of a premium rate in connection with enrollment in this health plan, in addition to any right otherwise available to revoke an offer, you may cancel such agreement within 72 hours after having signed an enrollment form. Cancellation occurs when written notice of cancellation is mailed to Humana, its representatives or the employer (Ohio HMO and POS plans only).

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

OH-72000-SA 1/2008

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.)