

Humana Employee Enrollment Application - 2-50 Employees

MISSOURI

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 Classic Medical plans and Life and Short-term income protection plans insured or administered by Humana Insurance Company. Dental plans insured or administered by HumanaDental Insurance Company or Humana 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

MO-80124-GN 5/2006

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

MO-80124-DP 5/2006

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
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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
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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
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Medical

MO-80124-MD 5/2006

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"/> Other			
Plan name	Network name		
HMO only:			
Employee primary care physician	Physician ID	Current Patient: <input type="radio"/> No <input type="radio"/> Yes	

Group Number

Social Security Number

Medical (continued)

The group plan/policy includes coverage for contraceptives unless your employer has chosen to exclude that coverage because such coverage is contrary to your employer’s moral, ethical, or religious beliefs or tenets. You have the right to include coverage of contraceptives, even if your employer has chosen to exclude such coverage. Please ask your employer if your plan offers contraceptive coverage and then select from the following options:

- a. If your employer has chosen to include contraceptive coverage and you wish to have such coverage, you do not have to do anything.
- b. If your employer has chosen to exclude contraceptive coverage and you wish to include such coverage, contact us to add contraceptive coverage to your plan.
- c. If your employer’s plan selection includes contraceptive coverage, you have the right to exclude coverage of prescription drugs or devices for use as contraceptives, if such coverage is contrary to your moral, ethical, or religious beliefs or tenets. Contact us to exclude contraceptive coverage from your plan.

You must submit your request to include or exclude coverage of contraceptives to us by verbal, written or electronic means, within 31 days of your initial or annual enrollment or policy anniversary date.

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 MO-80124-HD 5/2006

Group number _____ Benefit number _____ Class/Division _____

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

Plan name _____

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 MO-80124-HL 5/2006

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

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) \$ _____

Group Number

Social Security Number

Short-term Income Protection MO-80124-SP 5/2006

Group number Benefit number Class/Division

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

Class (employer will provide if needed)

Evidence of Health Status MO-80124-HS 5/2006

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 Short-term income protection or Life coverage.

1. Are you or any dependent currently under any treatment or prescribed medications? No Yes

2. Have you or any dependent had unexplained weight loss or fatigue in the past 12 months? No Yes

3. Have you or any dependent ever had, been diagnosed with, counseled, consulted or treated for any of the following within the past 5 years:

a. Chest pain; disease of heart, arteries or blood vessels; high or low blood pressure? No Yes

b. Nervous, mental or emotional disorder; convulsions; epilepsy; unconsciousness? No Yes

c. Asthma or other disease of lungs or respiratory organs? No Yes

d. Kidney stones; disease of kidney, bladder, male or female organs; or infertility? No Yes

e. Cancer, and/or cancerous tumor? (state type; part of body) No Yes

f. Diabetes; liver or thyroid disease; or enlargement of the lymph nodes? No Yes

g. Stomach, gall bladder, intestinal or colon disorders? No Yes

h. Rheumatoid arthritis or back disorders? No Yes

i. Phlebitis, paralysis, or any other physical impairment or deformity? No Yes

j. Alcoholism or drug habit, or been a member of Alcoholics Anonymous? No Yes

4. Have you or any dependent been diagnosed or received treatment for AIDS or an AIDS-related complex or other immune system disorder within the past 5 years? No Yes

5. Have you or any dependent been hospitalized or had hospitalization advised, had surgery or been advised to have surgery, had any injury, illness, medical attention or medical advice or treatment during the past 5 years for any reason not already mentioned? No Yes

6. Are you or any dependent pregnant or ever had a cesarean section? No Yes

7. Please provide height/weight information for all applicants enrolling for coverage:

	Height (ft / in)	Weight (lbs.)
a. Employee name		
b. Spouse name		
c. Dependent name		
d. Dependent name		
e. Dependent name		

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 __/__/____

Group Number

Social Security Number

Health Savings Account MO-80124-HA 5/2006

Group number Benefit number Class/Division

Do you elect the health savings account? No Yes

If you have medical coverage under another plan, you may not be eligible for an HSA. Please check with your tax advisor for details. 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's estate. You may change beneficiary information on file with the bank that administers the HSA once the account is established.

Waiver (Refusal of coverage) MO-80124-WV 5/2006

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

Medical for: <input type="radio"/> Myself <input type="radio"/> My spouse <input type="radio"/> My dependent child(ren)	Short-term income protection for: <input type="radio"/> Myself
Dental 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
Basic life for: <input type="radio"/> Myself <input type="radio"/> My spouse <input type="radio"/> My dependent child(ren)	

I decline to apply for group coverage because of (check all that apply): Spousal coverage Medicare supplement Individual coverage Coverage under another carrier's plan provided by my employer Other:

I understand and agree:

- In the event that I should decide to apply for such coverage hereafter, that such subsequent application shall be subject to the applicable terms and conditions of the master group contract(s) or plan provisions as described in the Summary Plan Description which may require additional limitations and waiting periods.
- I may be required to furnish, at my own expense, evidence of health status satisfactory to Humana.
- If I am declining coverage for myself or my dependents (including my spouse) because of other coverage, I may in the future be able to enroll myself or my dependents provided that I request enrollment within 31 days after my other coverage ends.
- If I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents provided that I request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

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: _____

Spouse signature: _____ Date: _____

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