## Small Group Employee Enrollment Form - 1-50 Employees — INDIANA

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in the Small Group Employee Enrollment Form as "Humana". To elect primary care physician or dentist, please complete reorder IN-51340-PP.

❍ Medical plans offered by ❍ Humana Health Plan, Inc. or insured or administered by ❍ Humana Insurance Company. ❍ Life plans insured or administered by ❍ Humana Insurance Company. ❍ Dental HMO plans offered by ❍ HumanaDental Insurance Company. ❍ Dental plans insured or administered by ❍ HumanaDental Insurance Company or ❍ Humana Insurance Company. ❍ Vision plans insured or administered by ❍ Humana Insurance Company or ❍ HumanaDental Insurance Company.

**Please print clearly and fill in each applicable circle.** | Proposed effective date: __/__/____

| Employer / Group name | Employer / Group city | State |
|---|---|---|
| | | |

**Qualifying Event Instructions** Date of Qualifying Event: __/__/____

❍ New business enrollment ❍ Open Enrollment event ❍ Dependent birth or adoption ❍ Loss of coverage
❍ New hire / Newly eligible ❍ Rehire / Reinstatement ❍ Marital status change ❍ Other_____

### Enrollment information

| Relationship | Last name, First name MI | Gender | Date of birth | Disabled? If yes, indicate reason below. | | Social Security Number |
|---|---|---|---|---|---|---|
| Employee / Individual | | ❍ F ❍ M | __/__/____ | ❍ Y ❍ N | | N/A (complete in Employee/ Individual Information section.) |
| Spouse / Domestic Partner | | ❍ F ❍ M | __/__/____ | ❍ Y ❍ N | | |
| Child / Dependent | | ❍ F ❍ M | __/__/____ | ❍ Y ❍ N | | |
| Child / Dependent | | ❍ F ❍ M | __/__/____ | ❍ Y ❍ N | | |
| Child / Dependent | | ❍ F ❍ M | __/__/____ | ❍ Y ❍ N | | |
| Other (specify): | | ❍ F ❍ M | __/__/____ | ❍ Y ❍ N | | |

### Employee / Individual Information

Hours worked per week: | Date of full time hire: __/__/____

| Social Security Number | Street address | APT / Suite / Box |
|---|---|---|
| | | |

| City | State | ZIP code | Phone # ( ) |
|---|---|---|---|
| | | | |

| Language: ❍ English ❍ Spanish ❍ Other | E-mail address | Occupation |
|---|---|---|
| | | |

Are you actively at work? ❍ Y ❍ N If not, reason: ❍ Retiree ❍ COBRA Other: _____ Annual salary $

**Prior / Existing Coverage:** **IMPORTANT - DO NOT** cancel any existing coverage until you receive written notification from Humana of your acceptance for coverage.

### Medical

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 / Individual only ❍ Employee / Individual and spouse ❍ Employee / Individual 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 / Individual only ❍ Employee / Individual and spouse ❍ Employee / Individual and child(ren) ❍ Family | Effective date __/__/____ |
|---|---|---|---|
| | | | Term date __/__/____ |

3. Medicare

| Employee / Individual coverage: ❍ N ❍ Y | Medicare ID | Effective date __/__/____ | Term date __/__/____ |
|---|---|---|---|
| Spouse coverage: ❍ N ❍ Y | Medicare ID | Effective date __/__/____ | Term date __/__/____ |

| Last name: | First name: |
|---|---|

**Dental**

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

2. Prior orthodontia coverage in the past 12 months? ❍ N ❍ Y

| Prior dental insurance carrier name | Policy # | Prior coverage type:<br>❍ Employee / Individual only<br>❍ Employee / Individual and spouse<br>❍ Employee / Individual and child(ren)<br>❍ Family |
|---|---|---|
| | Effective date _ _ / _ _ / _ _ _ _ | |
| Prior carrier phone # ( ) | Term date _ _ / _ _ / _ _ _ _ | |

**Coverage Options**

**Medical** **Group #:** **Benefit #:** **Class/Div:**

Coverage type: ❍ Employee / Individual only ❍ Employee / Individual and spouse ❍ Employee / Individual and child(ren) ❍ Family ❍ No Coverage (complete waiver)

Plan 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 employees / individual'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:**

Coverage type: ❍ Employee / Individual only ❍ Employee / Individual and spouse ❍ Employee / Individual and child(ren) ❍ Family ❍ No Coverage (complete waiver)

Rate Amount $_____ Rate Frequency (Monthly)
Rate Amount $_____ Rate Frequency (Monthly)
Rate Amount $_____ Rate Frequency (Monthly)
Rate Amount $_____ Rate Frequency (Monthly)

Plan name:

**Basic Life AD&D** **Group #:** **Benefit #:** **Class/Div:**

Basic dependent life ❍ N ❍ Y (If no, complete waiver.)

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

**Voluntary Life AD&D** **Group #:** **Benefit #:** **Class/Div:**

Voluntary employees / individual life coverage ❍ N ❍ Y

Amount (min $15,000) $

Voluntary spouse life coverage? ❍ N ❍ Y

Amount (min $5,000) $

Voluntary child(ren) life coverage? ❍ N ❍ Y

**Vision** **Group #:** **Benefit #:** **Class/Div:**

Coverage type: ❍ Employee / Individual only ❍ Employee / Individual and spouse ❍ Employee / Individual and child(ren) ❍ Family ❍ No Coverage (complete waiver)

Rate Amount $_____ Rate Frequency (Monthly)
Rate Amount $_____ Rate Frequency (Monthly)
Rate Amount $_____ Rate Frequency (Monthly)
Rate Amount $_____ Rate Frequency (Monthly)

Plan name:

**Beneficiary Information for Life**

| Primary beneficiary name (Last, First MI) | Relationship to Employee / Individual |
|---|---|
| Secondary beneficiary name (Last, First MI) | Relationship to Employee / Individual |

**Evidence of Health Status - Do not submit more than 90 days prior to the effective date.**

Complete this section if you are selecting Life over the guarantee issue amount.

| | | |
|---|---|---|
| 1. | Is anyone on this application currently taking any prescribed medication, or do you periodically take medication for a recurrent condition? | ❍ N ❍ Y |
| 2a. | In the past 12 months has any applicant used any tobacco product? If yes, applies to:<br>❍ Employee ❍ Spouse/Domestic Partner ❍ Other ❍ Child/Dependent | ❍ N ❍ Y |
| 2b. | Is any applicant currently a smoker? If yes, applies to:<br>❍ Employee ❍ Spouse/Domestic Partner ❍ Other ❍ Child/Dependent | ❍ N ❍ Y |
| 3. | In the past 12 months, have you missed 5 or more consecutive days of work due to an injury or illness other than as a result of a cold, the flu, back problems, strained/sprained/fractured/broken limb or as a result of pregnancy? | ❍ N ❍ Y |

| Last name: | First name: |
|---|---|

| | | |
|---|---|---|
| 4. | Has anyone on this application been diagnosed or received treatment for HIV or other immune system disorders? | ❍ N ❍ Y |
| 5. | Within the past 5 years, has anyone on this application been diagnosed with diseases or disorders related to, counseled, consulted, or treated by a doctor, including surgery, for any of the following: | |

| | | |
|---|---|---|
| a. | Coronary artery disease, chest pain, heart surgery, or any disease of the arteries, or blood disorders; anemia; hemophilia; phlebitis; high blood pressure (reading higher than 140/90)? | ❍ N ❍ Y |
| b. | Nervous, mental or emotional disorder; convulsions; epilepsy; unconsciousness; Multiple Sclerosis; Parkinson's Disease; Cerebral Palsy? | ❍ N ❍ Y |
| c. | Stroke; Transient Ischemic Attack (TIA)? | ❍ N ❍ Y |
| d. | Emphysema; asthma, or other disease of lungs, or respiratory organs? | ❍ N ❍ Y |
| e. | End stage renal disease; disease of kidney? | ❍ N ❍ Y |
| f. | Kidney stones; bladder? | ❍ N ❍ Y |
| g. | Male or female organs; or infertility? | ❍ N ❍ Y |
| h. | Cancer, and/or cancerous tumor; including skin cancer? | ❍ N ❍ Y |

| | | |
|---|---|---|
| i. | Diabetes; liver or thyroid disease; hepatitis; cirrhosis; or enlargement of the lymph nodes? | ❍ N ❍ Y |
| j. | Stomach, gall bladder, digestive, intestinal, or colon disorders? | ❍ N ❍ Y |
| k. | Rheumatoid arthritis; or back disorders; or joint disorders? | ❍ N ❍ Y |
| l. | Paralysis, or any other physical impairment or deformity? | ❍ N ❍ Y |
| m. | Chronic Fatigue Syndrome/Fibromyalgia? | ❍ N ❍ Y |
| n. | Diseases of the eye, ear, nose, or throat? Disease or disorder which has led or may lead to a permanent or progressive loss of vision, hearing or speech? | ❍ N ❍ Y |
| o. | Alcoholism or drug habit? | ❍ N ❍ Y |

| | | |
|---|---|---|
| 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? | ❍ N ❍ 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? | ❍ N ❍ Y |

| Relationship | Last name, First name MI | Height (ft / in) | Weight (lbs) |
|---|---|---|---|
| Employee | | / | |
| Spouse / Domestic Partner | | / | |
| Child / Dependent | | / | |
| Child / Dependent | | / | |
| Child / Dependent | | / | |
| Other (specify): | | / | |

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 IN-51340-MH), if necessary.

| Question # | 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 _ _ / _ _ / _ _ _ _ |

| Last name: | First name: |
|---|---|

## 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 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) | ❍ Spousal coverage |
| Dental for: | ❍ Myself | ❍ My spouse | ❍ My dependent child(ren) | ❍ Medicare supplement |
| Basic Life for: | ❍ Myself | ❍ My spouse | ❍ My dependent child(ren) | ❍ Individual coverage |
| Vision for: | ❍ Myself | ❍ My spouse | ❍ My dependent child(ren) | ❍ Coverage under another carrier's plan provided by my employer / group |
| Health Savings Account for: | ❍ Myself | | | ❍ Other:_____ |

## Agreement

**True and complete acknowledgment**

I understand, agree, and represent:

- I have read the Small Group Employee 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 Small Group Employee 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 Small Group Employee 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 Small Group Employee 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 Small Group Employee Enrollment Form.
- 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 Small Group Employee Enrollment Form by Humana.
- A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

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 Group Employee Enrollment Form, claim or as may be otherwise lawfully required, or as I (we) may further authorize.

| Last name: | First name: |
|---|---|

**Authorization for Release of Medical Records for Life**
If my dependents or I have selected life 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 Small Group Employee 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 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 / Individual or legal representative signature: _____ Date: _____

Name and relationship of legal representative: _____

Spouse signature: _____ Date:_____
(Only if selecting Life coverage over the guarantee issue amount.)

| **Agent / Producer Information** | |
|---|---|
| **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 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 Small Group Employee 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.

# Important!

## At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, marital status, or religion. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:
  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 their Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019**, **800-537-7697 (TDD)**. Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.
- **California residents**: You may also call California Department of Insurance toll-free hotline number: **1-800-927-HELP (4357)**, to file a grievance.

## Auxiliary aids and services, free of charge, are available to you. 1-877-320-1235 (TTY: 711)

Humana provides 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.

---

## Language assistance services, free of charge, are available to you. 1-877-320-1235 (TTY: 711)

**Español (Spanish):** Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.
**繁體中文 (Chinese):** 撥打上面的電話號碼即可獲得免費語言援助服務。
**Tiếng Việt (Vietnamese):** Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.
**한국어 (Korean):** 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오 .
**Tagalog (Tagalog – Filipino):** Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.
**Русский (Russian):** Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.
**Kreyòl Ayisyen (French Creole):** Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.
**Français (French):** Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.
**Polski (Polish):** Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.
**Português (Portuguese):** Ligue para o número acima indicado para receber serviços linguísticos, grátis.
**Italiano (Italian):** Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.
**Deutsch (German):** Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.
日本語 **(Japanese)**: 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。
**فارسی (Farsi)** .برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید

**Diné Bizaad (Navajo):** Wódahí béésh bee hani'í bee wolta'ígíí bich'į' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'dęę niká'adoowoł.
**العربية (Arabic)** الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

GCHJV5REN 0220