MISSOURI

Small Group Employee and Individual Application and Enrollment Form - 1-100 Employees

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in the Small Group Employee and Individual Application and Enrollment Form as "Humana".

- □ PPO and Indemnity Medical plans insured or administered by Humana Insurance Company.
- Dental plans insured or administered by HumanaDental Insurance Company or Humana Insurance Company.
- Vision plans insured or administered by Humana Dental Insurance Company or Humana Insurance Company.
 Short Term Disability, Long Term Disability and Workplace Voluntary plans insured or administered by Kanawha Insurance Company.

Please print clearly	and fill in eac	h applicable circle	•		Propose	ed effective date: _	_//	
Employer / Group name Employer / Group city						State		
Qualifying Event Inst O New business enrol O New hire / Newly eli	lment O Op	te of Qualifying Even pen Enrollment event ehire / Reinstatement	O D	ependent birth o Iarital status chai	r adoption nge	O Loss of coverc ○ Other	ige	
Enrollment information	on							
Relationship	Last name, Fi	rst name MI	Gender	Date of birth		isabled? cate reason below.	Social Security Number	
Employee / Individual			OF OM	/_/	OY ON		N/A (complete in Employee/ Individual Information section.)	
Spouse / Domestic Partner			O F O M	/_/	OY ON			
Child / Dependent			OF OM	/_/	OY ON			
Child / Dependent			O F O M	/_/	OY ON			
Child / Dependent			O F O M	/_/	OY ON			
Other (specify):			O F O M	/_/	O Y O N			
Employee / Individuo	l Information	Hours	s worked pe	er week:	Date of f	ull time hire: /	1	
Social Security Numbe		Street address					uite / Box	
City		5	State	ZIP code		Phone # ()		
Language: O English (🔾 Spanish 🔾 Oth	er E-mail address			Occupat	tion		
Are you actively at wo	rk?⊙Y⊙N Ifr	not, reason: 🔾 Retir	ee 🔾 CO	BRA Other:		Annual salary	\$	
Prior / Existing Cover	age: IMPORTAI your accer	NT - DO NOT cancel a otance for coverage.	ny existing) coverage until ya	ou receive wr	itten notification fr	om Humana of	
Medical								
1. Prior medical coverc	ige during the pas	st 18 months (individu	ual or other	r group coverage)	? O N O Y			
Prior medical insuranc carrier name		Prior coverage type: • Employee / Indivision spouse • Employee	idual only (C Employee / Ind	lividual and	ual and		
2. Other medical cover	age in effect at th				5			
2. Other medical coverage in effect at the same time as this HuOther medical insurance carrier namePolicy #Other coverage type: O Employee / Individ ansura O Employee / Employee / Individ			e: idual only (<u> </u>	lividual and	Effective date	e/_/	
3. Medicare			.,				<u>·' '</u>	
Employee / Individual	coverage: ONO	Y Medicare ID		Effective of	late / /	′ Term date	e/_/	
Spouse coverage: O N	ΟΥ	Medicare ID		Effective of	late / /		e/_/	

	Last nar	ne:		Firs	st name:	
Dental						
1. Prior dental cov	verage during the past 12 m	onths (individual or	other group cov	erage)? 🔾	ΝΟΥ	
2. Prior orthodon	tia coverage in the past 12 r	months? • N • Y				
Prior dental insur	ance carrier name	Policy	#		Prior coverage	e type: / Individual only
		Effecti	ve date//	,	O Employee /	'Individual and spouse
Prior carrier phon	e#()		late//		○ Employee / ○ Family	'Individual and child(ren)
Coverage Option					• Farmay	
			B (1. 11			
Medical	Group #:		Benefit #:		Class/Div	/:
Coverage type:	 Employee / Individual Employee / Individual No Coverage (complet) 	and child(ren) 🔾 Fa		Jouse	Plan name:	
Health Savings A	Account Group #:		Benefit #:		Class/Div	/:
Please refer to Hu information on H	cal coverage under another Imana's HSA contribution w SAs on Humana.com. Selec	orksheet to calculat t the Quick Link for S	te your maximur Spending Accour	m allowed o nt informati	contribution. Yo ion on the Mem	bu can find additional Nber page.
Do you elect the I ONOY (If no, c	Health Savings Account? omplete waiver.)					l's estate. You may change s the HSA once the account is
Dental	Group #:		Benefit #:		Class/Div	/:
Coverage type:	• Employee / Individual on • Employee / Individual an • Employee / Individual an • Family	d spouse Rate Ar d child(ren) Rate Ar Rate Ar	nount \$ R nount \$ R	Rate Frequei Rate Frequei	ncy (Monthly) ncy (Monthly) ncy (Monthly) ncy (Monthly)	Plan name:
Vision	• No Coverage (complete v Group #:	Valver)	Benefit #:		Class/Div	
Coverage type:	• Employee / Individual on	lv Rate Ar		ate Freque	ncy (Monthly)	Plan name:
coverage type.	• Employee / Individual an	d spouse Rate Ar	nount \$ F	Rate Freque	ncy (Monthly)	rannanc.
	• Employee / Individual an • Family				ncy (Monthly) ncy (Monthly)	
	• No Coverage (complete v					
Short Term Disa		Benefi			lass:	Div:
Short Term Disab	5		5 1 1	ercent/am		
Long Term Disat		Benefi			lass:	Div:
Long Term Disabi	y		, , , ,	ercent/am		
Workplace Volu	ntary Benefits: Optional rid	lers availability base	ed on employer /	group elec	tion.	
Accident	Group #:	Benefi	t #:	Cl	lass:	Div:
O Accident O N		O 1 O 2 O 3 O 4				
Coverage type:	• Employee / Individual o • Family	, , , , , , , , , , , , , , , , , , ,		•		
• \$150 ¢	ital Intensive Care Unit Ben ⊃ \$300 ⊃ \$450 ⊃ \$600		O \$7	50 O \$1	·	
• Optional Accid	dent Total Disability Benefits	s Rider: Eliminatior Monthly		DŐ O\$5	00 🔾 \$600	ays • 30 Days • \$700 • \$800
Accident - 2012	Group #:	Benefi		CI	ass:	Div:
O Accident O N		01020304				
Coverage type:	• Employee / Individual c • Family	only O Employee	/ Individual and	spouse C	Employee / Ir	ndividual and child(ren)

	Last name:				First name:		
Disability Income Plus Group)#:	Benefit #:			Class:	D	iv:
 Disability Income Covering Accid Base Benefit Period: 3 M Base Elimination Period: 0 0/7 9 90 	Month O 6 Month 7 O 7/7	DNOY h 01Y 00/1	4 O	2 Year 14/14	3 Year30/30	○ 60/60	Monthly Benefit \$
 Disability Income Covering Accide Base Benefit Period: O 3 M Base Elimination Period: O 0/7 	Month 🛛 🔾 6 Month		ear O	Period 2 Year 14/14	• N • Y • 3 Year		
Optional Disability Income Benefits:	• ICU / CCU Ber	nefit O \$2	00 🔾 \$400	○ \$600	r		
	O Physical Ther		COBRA R	ider	COBRA Monthly		
	roup #:	Benefit #:			Class:	D	iv:
 Disability Income Advantage Base Benefit Period: 3 M Base Elimination Period: 0 0/7 9 0,7 	Month O 6 Month 7 O 7/7	O 0/1	4 O	2 Year 14/14	• 3 Year • 30/30	O 60/60	Monthly Benefit \$
Optional Riders: O Hospital Conf	finement O COE	BRA Rider			COBRA Monthl	y Benefit \$	
Critical Illness Group)#:	Benefit #:			Class:	D	iv:
• Critical Illness • N • Y • Critical Illness and Cancer • N •	Coverage typ				only O Employ and child(ren)		and spouse
Optional Benefits: • Automatic Ber	nefit Increase ${f O}$ Hec	alth Screening	9	Employe	e / Individual Be	nefit \$	
Does anyone on this application hav prior to age 60? ONOY If yes, plea (Employee / Individual) O Spouse O	ase indicate whether	or sister with this applies t Name_	a history o to you (Emp	f heart a ployee / i	ttack, heart disea Individual), your	ase, stroke, or co spouse or a dep	ancer diagnosis pendent. O You
Group Lump Sum Cancer Group)#:	Benefit #:			Class:	D	iv:
• Group Lump Sum Cancer • N •	Y Coverage ty				only O Employ and child(ren)		and spouse
Does anyone on this application hav If yes, please indicate whether this a • You (Employee / Individual) • Sp	applies to you (Emplo	oyee / Individ	a history of ual), your s	f cancer pouse oi	diagnosis prior to r a dependent.	o age 60 ? 🔾 N 🤇	үс
Rider: • Automatic Benefit Increase	\mathbf{O} Health Screening	gs	Base Benef	fit \$			
Cancer Expense Group)#:	Benefit #:			Class:	D	iv:
O Cancer Expense O N O Y) Employee / Inc d(ren)) Fami		ouse
• Lump Sum Benefit (Equal to 50%	o of Base Benefit Amo	ount) Ride	r: 🔾 Hospi	tal Indei	mnity Rider	Base Benefit \$	
Supplemental Health Group)#:	Benefit #:			Class:	D	iv:
• Supplemental Health • N • Y	Coverage type:	O Employ O Employ			O Employee child(ren) O F	/ Individual and amily	spouse
Plan type: • 1 • 2 • 3 • 4							
Hospital Indemnity Group)#:	Benefit #:			Class:		iv:
O Hospital Indemnity O N O Y	Coverage type:				C Employee child(ren) O F	/ Individual and amily	spouse
Plan type: • 1 • 2 • 3 • 4							
If your employer or group has elected the critical illness benefit, 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? ON OY If yes, please indicate whether this applies to you (Employee / Individual), your spouse or a dependent.							
 You (Émployee / Individual) O Spouse O Dependent Name Beneficiary Information for Life, Disability and Workplace Voluntary Benefits 							
Primary beneficiary name (Last, First		_	-		ployee / Individu	al	
Secondary beneficiary name (Last, F	irst MI)		Relationshi	ip to Emj	ployee / Individu	al	

	Last name:				First name:			
Evic	lence of Health Status - Do not submit more than 90 (days p	rior	to tl	ne effective date.			
Con	nplete this section if you are selecting workplace voluntar	y (excl	udes	s Acc	ident) benefits and/or Life over the guarantee	issue an	nount.	
1. Is anyone on this application currently taking any prescribed medication, or do you periodically take medication for a recurrent condition?							О Ү	
2a.	In the past 12 months has any applicant used any tol O Employee O Spouse/Domestic PartnerO Other O					ΟN	О Ү	
2b.	Is any applicant currently a smoker? If yes, applies to O Employee O Spouse/Domestic PartnerO Other O		Depe	ende	ent	O N	О Ү	
3.	In the past 12 months, have you missed 5 or more co as a result of a cold, the flu, back problems, strained/s					O N	О Ү	
4. Within the last 12 months have you or any dependents to be covered been positively diagnosed or treated for: cancer, stroke, diabetes, heart or vascular disease, mental or emotional disorder, muscular or systemic disease (including but not limited to arthritis or lupus), alcohol or drug use, liver, kidney, lung or intestinal disorder, infertility, transplant (recommended, pending or completed), growth disorder, enlarged lymph nodes, or other immune disorders (to include positive diagnosis) for Acquired Immune Deficiency Syndrome (AIDS) or Aids Related Complex (ARC)?						O N	О Ү	
5.	Within the past 5 years, has anyone on this application consulted, or treated by a doctor, including surgery, for					seled,		
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)?	O N O Y					О N О Y	
b.	Nervous, mental or emotional disorder; convulsions; epilepsy; unconsciousness; Multiple Sclerosis; Parkinson's Disease; Cerebral Palsy?	О N О Y		j.	omach, gall bladder, digestive, intestinal, or colon sorders?			
C.	Stroke; Transient Ischemic Attack (TIA)?	О N О Y		k.	Rheumatoid arthritis; or back disorders; or joir disorders?	nt	ON OY	
d.	Emphysema; asthma, or other disease of lungs, or respiratory organs?						O N O Y	
e.	End stage renal disease; disease of kidney?	О N О Y		m.	n. Chronic Fatigue Syndrome/Fibromyalgia?			
f.	Kidney stones; bladder?O N O YDiseases 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?				0 N 0 Y			
g.						O N O Y		
h.	Cancer, and/or cancerous tumor; including skin cancer?	О N О 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?						O N	О Ү	
7.	Within the past 5 years, has anyone on this applicatic physical/wellness exam, or been seen for any reason					ON	О Ү	
8.	Is anyone on this application currently pregnant? If ye Anticipated delivery date:	es, plec	ise ir	ndico	ate anticipated delivery date below.	ON	О Ү	
9.								

	Last name:	First name:		
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 (found at the end of this form), 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//			

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 (chec	I de	ecline to apply for group coverage		
Medical for:	• Myself	• My spouse • My dependent child(ren)		ause of:
Dental for:	O Myself	\mathbf{O} My spouse \mathbf{O} My dependent child(ren)	0	Spousal coverage
Vision for:	O Myself	\mathbf{O} My spouse \mathbf{O} My dependent child(ren)	0	Medicare supplement
Short Term Disability for:	O Myself		0	Individual coverage
Long Term Disability for:	O Myself		0	Coverage under another carrier's plan
Health Savings Account for:	• Myself			provided by my employer / group
Waive Coverage for Workplace	Voluntary B		0	Other:
Critical Illness for:	O Myself	• My spouse • My dependent child(ren)		
Group Lump Sum Cancer for:	• Myself	\mathbf{O} My spouse \mathbf{O} My dependent child(ren)		
Cancer Expense for:	O Myself	O My spouse O My dependent child(ren)		
Supplemental Health for:	O Myself	\mathbf{O} My spouse \mathbf{O} My dependent child(ren)		
Accident for:	• Myself	\bigcirc My spouse \bigcirc My dependent child(ren)		
Hospital Indemnity for:	• Myself	\bigcirc My spouse \bigcirc My dependent child(ren)		
Disability Income Plus for:	• Myself			
Disability Income Advantage for:	O Myself			

Agreement

True and complete acknowledgement

I understand, agree, and represent:

- I have read the Small Group Employee and Individual 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 Small Group Employee and Individual 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 Small Group Employee and Individual 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.

Last name:	First name:

- 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 and Individual 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 Small Group Employee and Individual 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 Small Group Employee and Individual 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 Small Group Employee and Individual Application and Enrollment Form by Humana.
- Any person who willingly and knowingly submits the Small Group Employee and Individual 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 Group Employee and Individual 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 Small Group Employee and Individual 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 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:
 Date:

 Spouse signature:
 Date:

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

Last name:	First name:
Agent / Producer Information	
f applying for workplace voluntary benefits, this se	ection 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:

As the Writing Agent / Producer, I acknowledge that I am responsible to meet with the primary applicant submitting the Small Group Employee and Individual 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		
5	County	State

 Writing Agent's Signature ______
 Date __/__/____

	Last name:	First name:			
Additional Details to Medical G	Questions				
This information should not be Please print clearly.	submitted more than 60 days p	prior to the effective date.			
Question # & letter	Person treated (Last name, First	t name)			
Condition		Treatments received			
Medications prescribed		Current or future treatments or med	ications		
Date diagnosed//	-	Date last seen by a doctor/_/			
Question # & letter	Person treated (Last name, First	t name)			
Condition		Treatments received			
Medications prescribed		Current or future treatments or med	ications		
Date diagnosed//	-	Date last seen by a doctor//	·		
Question # & letter	Person treated (Last name, First	t name)			
Condition		Treatments received			
Medications prescribed		Current or future treatments or med	ications		
Date diagnosed//	-	Date last seen by a doctor//			
Question # & letter	Person treated (Last name, First	t name)			
Condition		Treatments received			
Medications prescribed		Current or future treatments or med	ications		
Date diagnosed//	-	Date last seen by a doctor//	'		
Question # & letter	Person treated (Last name, First	t name)			
Condition		Treatments received			
Medications prescribed		Current or future treatments or med	ications		
Date diagnosed//	-	Date last seen by a doctor//	'		
Question # & letter	Person treated (Last name, First	t name)			
Condition		Treatments received			
Medications prescribed		Current or future treatments or med	ications		
Date diagnosed//	-	Date last seen by a doctor//			
[Employee] signature			Date / /		
Child signature (if covered depen					

Child signature (if covered dependent over the legal age) ____

PPO and Indemnity Medical plans insured or administered by Humana Insurance Company.
 Workplace Voluntary plans insured or administered by Kanawha Insurance Company.

Date__/__/

Visit us at Humana.com

MISSOURI

Small Group Employee and Individual Application and Enrollment Form - DHMO - 1-100 Employees

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in the Small Group Employee and Individual Application and Enrollment Form as "Humana". Election of primary dentist can be done on last page of this form. Dental HMO offered by CompBenefits Dental, Inc., 1100 Employers Blvd, Green Bay WI, 54344, Tel: 1-800-233-4013.

Please print c	learly and fill i	n each ap	plicable circle				Proposed effectiv	ve date: _	_//
Employer / Group name Employer / Gro					r / Grou	oup city State			
Qualifying Event Instructions Date of Qualifying Event:// O New business enrollment O Open Enrollment event O Dependent birth or adoption O New hire / Newly eligible O Rehire / Reinstatement O Marital status change O ther									
Enrollment info	ormation								
Relationship	Last no	ıme, First n	ame MI	Gender	Date of birt	h If	Disabled? yes, indicate reaso		
Employee / Individual				OF OM	//		P Y P N		N/A (complete in Employee/ Individual Information section.)
Spouse / Domestic Partner				O F O M	//	0	Y N		
Child / Dependent				O F O M	//		Y N		
Child / Dependent				O F O M	/_/	0	Y N		
Child / Dependent				O F O M	/_/		Y N		
Other (specify):				O F O M	//		Y N		
Employee / Ind	ividual Informat	tion	Hour	s worked p	er week:		Date of full time hi	re:/_	_/
Social Security N	lumber		Street address	5		I			uite / Box
City				State	ZIP code		Phone # ()	
Language: 🔾 Er	nglish ${f O}$ Spanish	• Other	E-mail address				Occupation		
Are you actively	at work? • Y •	N If not, re	eason: 🔾 Reti	ree OCC	BRA Other:_		Annu	al salary	\$
Prior / Existing			DO NOT cancel (e for coverage.	any existing) coverage until	you re	eceive written notif	ication fr	om Humana of
Dental									
1. Prior dental co	overage during th	e past 12 m	onths (individu	al or other o	group coverage)? O N	ОY		
	ntia coverage in t	•	nonths? ON O	Y					
Prior dental insu	irance carrier nan	ne	Po	licy #			Prior coverage type: • • • • • • • • • • • • • • • • • • •		
					e//		 Employee / Indi Employee / Indi 		
Prior carrier pho	ne # ()		Te	rm date	//		O Family		

	Last name:		First name:		
Coverage Option	ns				
Dental	Group #:	Benefit #:	Class/Di	v:	
Coverage type:	• Employee / Individual only • Employee / Individual and spouse	Rate Amount \$ Rate Amount \$	_Rate Frequency (Monthly) Rate Frequency (Monthly)	Plan name:	
	 Comployee / Individual and child(ren) Complete Waiver) 	Rate Amount \$ Rate Amount \$	_ Rate Frequency (Monthly) _ Rate Frequency (Monthly)		

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				I decline to apply for group coverage
Dental for:	O Mysell O Mys	spouse 🔾 r	My dependent child(ren)	because of: O Spousal coverage
				• Medicare supplement
				• Individual coverage
				• Coverage under another carrier's plan
				provided by my employer / group
				• Other:

Agreement

True and complete acknowledgment

I understand, agree, and represent:

- I have read the Small Group Employee and Individual 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 Small Group Employee and Individual 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 Small Group Employee and Individual 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 coverage and/or deny life or dental coverage with any future submissions of the Small Group Employee and Individual Application and Enrollment Form for coverage.
- If any deductions are required for this coverage, I authorize those deductions from my earnings.
- 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 and Individual 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 Small Group Employee and Individual 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 Small Group Employee and Individual Application and Enrollment Form by Humana.
- Any person who willingly and knowingly submits the Small Group Employee and Individual 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.

Last name:

First name:

My dependents and I understand and agree:

Authorization

- 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 and Individual Application and Enrollment Form, claim or as may be otherwise lawfully required, or as I (we) may further authorize.

The Small Group Employee and Individual 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 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:

Name and relationship of legal representative: _____

Spouse signature:

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

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)? ONOY

As the Writing Agent / Producer, I acknowledge that I am responsible to meet with the primary applicant submitting the Small Group Employee and Individual 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

Writing Agent's Signature

State

Date / /

Date:

Date: _____

Humana Employee Primary Dentist Selection

Last name:

The offering company listed below, severally or collectively, as the content may require, is referred to in this application as "Humana". Dental HMO and Advantage Plans offered by CompBenefits Dental, Inc., 1100 Employers Blvd, Green Bay WI, 54344, Tel: 1-800-233-4013.

Please print clearly and fill in each applicable circle.

Primary Dentist Sel	ection			
	Member Last name First name MI	Primary dentist name	Dentist ID	Current patient
Employee / Individual				O N O Y
Spouse / Domestic Partner				O N O Y
Child / Dependent				O N O Y
Child / Dependent				O N O Y
Child / Dependent				O N O Y
Other (specify)				O N O Y

Employee or legal representative signature:	 Date:
Name and relationship of legal representative:	

Visit us at Humana.com

MISSOURI

Small Group Employee and Individual Application and Enrollment Form- LIFE - 1-100 Employees

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in the Small Group Employee and Individual Application and Enrollment Form as "Humana" or 'Kanawha".

Basic and Voluntary Life plans insured or administered by Humana Insurance Company.
 Whole Life and Level Term Life plans insured or administered by Kanawha Insurance Company.

Please print cl	early and fill i	n each appl	icable circle.			Propo	sed effective date: _	_//
Employer / Group name Employer / Group city State							State	
Qualifying Even O New business O New hire / New	enrollment	O Open Enr	u alifying Event ollment event reinstatement	O	Dependent birth o Aarital status cho		 ❑ Loss of coverc ❑ Other 	ige
Enrollment info	rmation							
Relationship	Last na	me, First naı	ne MI	Gender	Date of birth	If yes, inc	Disabled? dicate reason below.	Social Security Number
Employee / Individual				OF OM	//	O Y O N		N/A (complete in Employee/ Individual Information section.)
Spouse / Domestic Partner				OF OM	//	O Y O N		
Child / Dependent				OF OM	/_/	O Y O N		
Child / Dependent				O F O M	//	O Y O N		
Child / Dependent				OF OM	//	O Y O N		
Other (specify):				OF OM	/_/	O Y O N		
Employee / Indi	ividual Informat	ion	Hours	worked p	er week ·	Date of	full time hire:/_	1
Social Security N			Street address	nonicap		Date of		uite / Box
City			St	tate	ZIP code		Phone # ()	
Language: 🔾 En	glish 🔾 Spanish	O Other E-I	mail address		I	Occup	ation	
Are you actively a	at work? • Y • I	N If not, rea	son: 🔾 Retire	e OCC	BRA Other:	·	Annual salary	\$
Coverage Option	ns							
Basic Life AD&D) (iroup #:		Ben	efit #:	Cl	ass/Div:	
Basic dependent l			vaiver.) C				iis information, if nee	eded)
Voluntary Life A	AD&D (iroup #:		Ben	efit #:	Cl	ass/Div:	
Voluntary emplo	5				mount (min \$15,			
Voluntary spouse	e life coverage? C		mount (min \$5	5,000) \$		Volunto	ry child(ren) life cove	erage? ONOY
Workplace Volu	Intary Benefits:	Optional rider	s availability bo	ased on ei	mployer / group	election.		
Whole Life /AD&	SD Gro	oup #:	Ben	efit #:		Class:	D	Div:
◯ Whole Life / A	D&D ONOY	O\	Whole Life 99	O Wh	ole Life 65 E	mployee / Ir	ndividual Benefit \$	
• AD&D Rider	• Automatic Pr	emium Loan	Option					
O Automatic Be O \$1 / Week O \$2 / Week		der			dual Term Rider t dual Benefit		amily Term Rider pouse Benefit Chilc \$	l(ren) Benefit

		Last name:			First name:										
Whole	Life Spo	ouse /AD&	хD	Group #:		Benefit #:		C	lass:		Div	:			
O Star	nd Alone	Spouse /	AD&D	ΟΝΟΥ	0	Whole Life 99	O Whole L	ife 65	Spo	use Ber	nefit \$				
O ADS	D Rider	• Fan	nily Tei	rm Rider (Chil	d Cove	erage Only) Child(re	n) Benefit Am	ount \$		O Au	tomatic Premiun	n Loc	in O	ptio	n
Whole	Life Chi	ldren /AD	0&D	Group #:		Benefit #:		C	lass:		Div	:			
O Wh	ole Life C	hild(ren)/	AD&D	$\mathbf{O} \ N \ \mathbf{O} \ Y$											
Child(r	en) listec	l here mu	st also	be included o	as dep	endents under the	Enrollment In	formati	on secti	on of th	nis application.				
ONC	Y Cover	age on Ch	ild 1	Child 1 nam	ne						Child 1 Benefit S	\$			
ONC	Y Cover	age on Ch	ild 2	Child 2 nam	ne						Child 2 Benefit S	\$			
ONC	Y Cover	age on Ch	ild 3	Child 3 nam	ne						Child 3 Benefit 3	\$	_		
Level 1	Term Lif	e	G	iroup #:		Benefit #:		C	lass:		Div	:			
O Leve O N C		ife / AD&D)	Coverage typ		 Employee / Indi Spouse O Child 					r Term 🔾 20-Yeai Nutomatic Benefi			se	
Emplo	yee / Ind	ividual Be	nefit \$)	Spou	use Benefit \$			Child(r	en) Bei	nefit \$				
of hear (Emplo	rt attack, byee / Inc	, heart dis dividual), y	ease, s /our sp		cer dia pende	Iness rider, have yo Ignosis prior to age nt. Ident Name_									
					y and	Workplace Volun									
Primar	y benefic	ciary nam	e (Last	, First MI)			Relationship t	o Emplo	oyee / In	dividuc	ıl				
Second	dary ben	eficiary na	ame (L	ast, First MI)			Relationship t	o Emplo	oyee / In	dividuc	ıl				
Eviden	nce of He	alth Stat	us - D	o not submit	t more	than 90 days pri	or to the effe	ctive do	ate.						
Compl	ete this s	ection if y	vou are	selecting wo	rkplac	e voluntary (exclud	les Accident)	penefits	and/or	Life ove	er the guarantee	issue	e am	nour	nt.
1.	Is anyo for a rea	ne on this current co	applic nditior	ation current n?	ly taki	ng any prescribed r	nedication, or	do you	periodic	ally tał	ke medication	0	Ν	0	Y
2a.	In the p • Emp	ast 12 ma loyee 🔾 S	onths h pouse	nas any applic /Domestic Pa	cant us Irtner (sed any tobacco pr • Other • Child/De	oduct? If yes, ependent	applies t	to:			0	Ν	0	Y
2b. Is any applicant currently a smoker? If yes, applies to: • Employee • Spouse/Domestic Partner • Other • Child/Dependent							0	Ν	0	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?							0	Ν	0	Y					
4.	cancer, (includi infertilit immun	stroke, die ng but no zy, transpl	abetes t limite ant (re s (to ir	, heart or vas ed to arthritis commended iclude positive	cular c or lup , pend	dependents to be lisease, mental or d us), alcohol or druc ing or completed), nosis) for Acquired	emotional disc use, liver, kidı growth disord	order, m ney, lung er, enlar	uscular g or integ rged lym	or syste stinal d oph noc	emic disease isorder, les, or other	0	N	0	Y

		Last name:			First name:						
5.	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.	any disease of the arte	e, chest pain, heart surgery, or eries, or blood disorders; anemia; high blood pressure (reading	O N O Y	i.	Diabetes; liver or thyroid disease or enlargement of the lymph no	; hepatitis; ci des?	rrhosi	S;	ON OY		
b.	Nervous, mental or em epilepsy; unconscious; Parkinson's Disease; Ce	notional disorder; convulsions; ness; Multiple Sclerosis; erebral Palsy?	ON OY	j.	Stomach, gall bladder, digestive disorders?	, intestinal, oi	r color	ſ	О N О Y		
C.	Stroke; Transient Ische	emic Attack (TIA)?	О N О Y	k.	Rheumatoid arthritis; or back dis disorders?	sorders; or joi	nt		О N О Y		
d.	Emphysema; asthma, respiratory organs?	or other disease of lungs, or	О N О Y	l.	Paralysis, or any other physical in deformity?	mpairment o	r		О N О Y		
e.	End stage renal diseas	e; disease of kidney?	О N О Y	m.	Chronic Fatigue Syndrome/Fibro	myalgia?			О N О Y		
f.	Kidney stones; bladdei	r?	O N O Y	n.	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?			t	О N О Y		
g.	Male or female organs	; or infertility?	O N O Y	0.				О N О Y			
h.	Cancer, and/or cancerd	ous tumor; including skin cancer?	О N О Y								
6.		application been advised by a me urgery that has not been complet				nostic test,	0	N	О Ү		
7.		ears, has anyone on this applicatio xam, or been seen for any reason				outine	0	N	О Ү		
8.	Is anyone on this ap Anticipated delivery	oplication currently pregnant? If ye / date:	es, plea	se indice	ate anticipated delivery date belo	W.	0	N	О Ү		
	Relationship	Las	st nam	e, First	name MI	Heig (ft /			eight bs)		
	Employee					/					
Sp	ouse / Domestic Partner					/					
	Child / Dependent					/					
	Child / Dependent					/					
	Child / Dependent					/					
Other (specify):						/					
If you	u answered "yes" to any ed and dated sheets (fou	of the questions above, please pr und at the end of this form), if nec	ovide c essary.	letails b	elow and specify the question nu	mber. Attach	additi	ionc	al		
Que	estion # Pers	on treated (Last name, First name	2)								
Con	dition			Treatm	nents received						
Med	dications 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 or Kanawha into waiving (declining) coverage. If I have waived any coverage offered to me or my dependents, my signature is evidence of this action.

eck all that app	oly):		I decline to apply for group coverage
O Myself	O My spouse	• My dependent child(ren)	because of:
e Voluntary B	enefits:	5	• Spousal coverage
• Myself	O My spouse	• My dependent child(ren)	• Medicare supplement
			• Individual coverage
2	5 1	5	• Coverage under another carrier's plan
			provided by my employer / group
			• Other:
	O Myself e Voluntary B O Myself	e Voluntary Benefits: O Myself O My spouse	• Myself • • My spouse • My dependent child(ren)

Agreement

True and complete acknowledgment

I understand, agree, and represent:

- I have read the Small Group Employee and Individual 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 has the authority to waive any question, determine coverage or insurability, alter any contract or waive any of Humana's or Kanawha's other rights and requirements.
- If the Small Group Employee and Individual Application and Enrollment Form for coverage is accepted, coverage will be effective on the date specified by Humana or Kanawha 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 and Individual 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 or Kanawha.
- 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 or Kanawha reserves the right to delay medical coverage and/or deny life or dental coverage with any future submissions of the Small Group Employee and Individual Application and Enrollment Form for coverage.
- If any deductions are required for this coverage, I authorize those deductions from my earnings.
- 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 and Individual Application and Enrollment Form.
- If I have selected workplace voluntary benefits, and if coverage is not issued as initially applied for, I hereby authorize Kanawha to decrease or increase the premium or rate amount stated on the Small Group Employee and Individual 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 Small Group Employee and Individual Application and Enrollment Form by Humana or Kanawha.
- Any person who willingly and knowingly submits the Small Group Employee and Individual 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 us 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 us 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 and Individual 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, 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 us, 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 and Individual 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 group coverage.

If you decide not to sign this authorization, we 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: _____

Name and relationship of legal representative: _____

Spouse signature: ____

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

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)
HAN Agent #	HAN Agent #
Commission split:	Commission split:
1. Writing Agent / Producer:	2. Writing Agent / Producer:
Name (print)	Name (print)
HAN Agent #	HAN Agent #
Commission split:	Commission split:

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

As the Writing Agent / Producer, I acknowledge that I am responsible to meet with the primary applicant submitting the Small Group Employee and Individual 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

Writing Agent's Signature _____

State

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.

5

First name:

Date:

Date: _____

Last name:

	Last name:	First name:				
Additional Details to Medical	Questions					
This information should not be Please print clearly.	submitted more than 60 days	prior to the effective	e date.			
Question # & letter	Person treated (Last name, Fir					
Condition		Treatments receiv	ved			
Medications prescribed		Current or future	treatments or medic	cations		
Date diagnosed//		Date last seen by	a doctor//			
Question # & letter	Person treated (Last name, Fir	st name)				
Condition		Treatments receiv	ved			
Medications prescribed		Current or future	treatments or medic	cations		
Date diagnosed//		Date last seen by	a doctor//			
Question # & letter	Person treated (Last name, Fir	st name)				
Condition		Treatments receiv	ved			
Medications prescribed		Current or future treatments or medications				
Date diagnosed//		Date last seen by a doctor//				
Question # & letter	Person treated (Last name, Fir	st name)				
Condition		Treatments receiv	ved			
Medications prescribed		Current or future treatments or medications				
Date diagnosed//		Date last seen by	a doctor//			
Question # & letter	Person treated (Last name, Fir	st name)				
Condition		Treatments receiv	ved			
Medications prescribed		Current or future treatments or medications				
Date diagnosed//		Date last seen by a doctor//				
Question # & letter	Person treated (Last name, Fir	st name)				
Condition		Treatments receiv	ved			
Medications prescribed	Current or future treatments or medications					
Date diagnosed//		Date last seen by	a doctor//			
Employee signature				Date//		
Spouse signature (if covered dep						
Child signature (if covered deper						
	ident over the legal age)					

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

Basic and Voluntary Life plans insured or administered by Humana Insurance Company.
 Whole Life and Level Term Life plans insured or administered by Kanawha Insurance Company.

Visit us at Humana.com

MISSOURI

Small Group Employee Enrollment Form - 1-100 Employees

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".

Indemnity Medical plans insured or administered by Humana Insurance Company.

Please print clearly and fill in each applicable circle.						Proposed effective date://		
Employer / Group name				Employer / Group city			State	
Qualifying Event Instr O New business enrollr O New hire / Newly elig	ment O	te of Qualifying Event: pen Enrollment event ehire / Reinstatement	OD	ependent birth or arital status char		 ❑ Loss of coverc ❑ Other 	ige	
Enrollment information	n							
Relationship	nship Last name, First nar		Gender Date of birth If		Disabled? If yes, indicate reason below.		Social Security Number	
Employee			O F O M	//	O Y O N		N/A (complete in Employee Information section.)	
Spouse / Domestic Partner			O F O M	//	O Y O N			
Child / Dependent			O F O M	//	O Y O N			
Child / Dependent			O F O M	//	O Y O N			
Child / Dependent			O F O M	/_/	O Y O N			
Other (specify):			O F O M	/_/	O Y O N			
Employee Information		Hours	workod po	n wook:	Data of fu	Ill time bire: /	1	
Employee InformationSocial Security NumberStr		Street address				Date of full time hire:// APT / Suite / Box		
City		St	ate	ZIP code		Phone # ()		
Language: 🔾 English C	Spanish 🔾 Oth	er E-mail address			Occupat	ion		
Are you actively at work	«?OYON Ifr	not, reason: 🔾 Retire	e OCO	BRA 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		5						
1. Prior medical coverage	je during the pas	st 18 months (other gro	oup cover	age)? O N O Y				
Prior medical insurance carrier name Policy # Prior coverage type: • Coverage type:							Effective date// Term date//	
2. Other medical covera	ige in effect at th	1 3		5	up coverage		.''	
Other medical insurance carrier namePolicy #Other coverage type: • Employee only • E • Employee and child		Employee and spouse d(ren) Q Family			Effective date// Term date//			
3. Medicare							·· ·	
Employee coverage: O	Medicare ID		Effective d	ate//	Term date	e/_/		
Spouse coverage: O N	γC	Medicare ID		Effective d	ate / /	Term date	e/_/	

Last name: Fir			st name:			
Coverage Option	S					
Medical	Group #:	Benefit #:	Class/Div:			
Coverage type:	 ○ Employee only ○ Employee and : ○ Employee and child(ren) ○ Famil ○ No Coverage (complete waiver) 		Plan 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 co Medical for:	verage for (check all that apply): O Myself O My sp	ouse O My dependent child(ren)	I decline to apply for group coverage because of: Spousal coverage Medicare supplement Individual coverage Coverage under another carrier's plan provided by my employer / group 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 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 a group's coverage as specified under the terms of the Policy or Certificate. Providing incomplete, inaccurate, or untimely information may reduce a 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.
- Any person who willingly and knowingly submits the Small Group Employee 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.

	Last name:	ŀ	First name:
Authorization			
 coverage, eligibility for benefits ur Any information obtained will not Medical Information Bureau, Inc. 	of this authorization may be used by Ider an existing policy and plan adm be released by Humana to any pers or other persons or organizations pe	ninistration. son or organizatio erforming health (xe claims determinations, determine eligibility for on except to reinsuring companies, the care operations or business or legal services e lawfully required, or as I (we) may further
Signature - please sign below if er	rolling or waiving group coverag	e.	
If you decide not to sign this authoriz inability to obtain the necessary infor	ation, Humana cannot complete yo mation.	ur plan enrollmer	nt or determine your premium rate due to the
Employee or legal representative sign	ature:		Date:

Name and relationship of legal representative: _____

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.