Humana Insurance Company of New York Small Group Employee Enrollment Form - 1-100 Employees NEW YORK

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 dentist, please complete reorder NY-51340-PP.

Dental and Vision plans insured or administered by Humana Insurance Company of New York, 125 Wolf Road, Suite 501, Albany, NY 12205-1253.

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.

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:
	Effective date __/__/____	❍ Employee / Individual only ❍ Employee / Individual and spouse ❍ Employee / Individual and child(ren) ❍ Family
Prior carrier phone # ( )	Term date __/__/____	

Last name:	First name:

Coverage Options

Dental	Group #:	Benefit #:	Class/Div:

Coverage type:
- ❍ Employee / Individual only — Rate Amount $_____ Rate Frequency (Monthly)
- ❍ Employee / Individual and spouse — Rate Amount $_____ Rate Frequency (Monthly)
- ❍ Employee / Individual and child(ren) — Rate Amount $_____ Rate Frequency (Monthly)
- ❍ Family — Rate Amount $_____ Rate Frequency (Monthly)
- ❍ No Coverage (complete waiver)

Plan name:

Vision	Group #:	Benefit #:	Class/Div:

Coverage type:
- ❍ Employee / Individual only — Rate Amount $_____ Rate Frequency (Monthly)
- ❍ Employee / Individual and spouse — Rate Amount $_____ Rate Frequency (Monthly)
- ❍ Employee / Individual and child(ren) — Rate Amount $_____ Rate Frequency (Monthly)
- ❍ Family — Rate Amount $_____ Rate Frequency (Monthly)
- ❍ 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 coverage for (check all that apply):
Dental for: ❍ Myself ❍ My spouse ❍ My dependent child(ren)
Vision for: ❍ Myself ❍ My spouse ❍ 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.
- 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 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.

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:

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.

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.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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: _____

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:

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.