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". To elect primary care physician or dentist, please complete reorder FL-51340-PP.

PPO, EPO and Indemnity plans insured by ❍ Humana Health Insurance Company of Florida, Inc. POS, HMO and National POS plans offered by ❍ Humana Medical Plan, Inc. Prepaid plans offered and administered by ❍ CompBenefits Company. All other Dental plans, Vision and Life plans insured or administered by ❍ Humana Insurance Company. Short Term Disability, Long Term Disability and Workplace Voluntary Benefits insured or administered by ❍ Kanawha 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 _ _ / _ _ / _ _ _ _

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

Whole Life

Do you have existing life insurance policies or annuity contracts? ❍ N ❍ Y

Will any of the policies applied for replace any coverage currently in force? ❍ N ❍ Y

Prior life insurance carrier name	Policy #	Prior coverage type: ❍ Employee / Individual only ❍ Employee / Individual and spouse ❍ Employee / Individual and child(ren) ❍ 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:

For medical plans only: Do you wish to extend coverage for your dependent adult child(ren) up to age 30? ❍ No ❍ Yes

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:

Short Term Disability **Group #:** **Benefit #:** **Class:** **Div:**

Short Term Disability ❍ N ❍ Y (If no, complete waiver.) Buy-up percent/amount _____

Long Term Disability **Group #:** **Benefit #:** **Class:** **Div:**

Long Term Disability ❍ N ❍ Y (If no, complete waiver.) Buy-up percent/amount _____

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

Excluding HIV/AIDS/ARC, 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 FL-51340-MH), if necessary.

Question #	Person treated (Last name, First name)
Condition	Treatments received
Medications prescribed	Scheduled treatments or medications
Date diagnosed _ _ / _ _ / _ _ _ _	Date last seen by a doctor _ _ / _ _ / _ _ _ _

Waiver (refusal of coverage)

I hereby waive coverage for (check all that apply):

Medical for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Dental for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Basic Life for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Vision for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Short Term Disability for:	❍ Myself		
Long Term Disability for:	❍ Myself		
Health Savings Account for:	❍ Myself		

Waive Coverage for Workplace Voluntary Benefits:

Whole Life for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Level Term Life for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Critical Illness for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Group Lump Sum Cancer for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Cancer Expense for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Supplemental Health for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Accident for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Hospital Indemnity for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Disability Income Plus for:	❍ Myself		
Disability Income Advantage for:	❍ Myself		

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 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.
- 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.

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 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. This authorization is valid for 24 months and can be revoked at any time. The signature is true and accurate and a copy of the signature is valid as the original.

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.

Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

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

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 #
Florida License ID #	Florida License ID #
Commission split:	Commission split:
1. Writing Agent / Producer:	**2. Writing Agent / Producer:**
Name (print)	Name (print)
Humana Agent #	Humana Agent #
Florida License ID #	Florida License ID #
Commission split:	Commission split:

Agent replacement question:

Will the coverage selected replace or change any existing life or disability 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 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 State

Writing Agent's Signature _____ Date __ __/__ __/__ __ __ __