

Group Employee/Member Enrollment Form (all group sizes)



SOUTH CAROLINA

Humana.com

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in this Group Employee Enrollment Form as “Humana”, “We”, “Us”, or “Our”.

Dental, Vision, Life and Disability plans insured or administered by **Humana Insurance Company**.

Print clearly and completely fill in each applicable circle.

Employer / Group name	Employer / Group city	State

Qualifying Event Instructions	Office use only
<input type="checkbox"/> New business enrollment <input type="checkbox"/> Open Enrollment event <input type="checkbox"/> New hire/Newly eligible <input type="checkbox"/> Rehire/Reinstatement <input type="checkbox"/> Dependent birth or adoption <input type="checkbox"/> Marital status change <input type="checkbox"/> Loss of coverage <input type="checkbox"/> Other _____	Qualifying event date (MM/DD/YYYY) <hr/> Benefit effective date (MM/DD/YYYY)

EMPLOYEE/ INDIVIDUAL INFORMATION - Please type or print clearly in black ink

Last name:	First name:	MI:
Social Security Number:	Date of birth (MM/DD/YYYY):	Phone number:
Street address:		
Apt / Suite / PO box number:	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	Language of choice: <input type="checkbox"/> English <input type="checkbox"/> Spanish
City:	State:	ZIP code: County:
Email address:		
Are you actively at work? <input type="checkbox"/> Yes <input type="checkbox"/> No If not, reason: <input type="checkbox"/> Retiree <input type="checkbox"/> COBRA Other: _____	Date of full-time hire (MM/DD/YYYY):	
Do you have a disability that affects your ability to communicate or read? <input type="checkbox"/> No <input type="checkbox"/> Yes Are you disabled or unable to perform normal work activities? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, indicate reason: _____		
Annual salary: \$	Hours worked per week:	
Occupation:		

DEPENDENT INFORMATION - Enter information for each covered dependent, including spouse.

1 Dependent last name:	First name:	MI:	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male
Social Security Number:	Date of birth (MM/DD/YYYY):	Relationship: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:	
Dependent status (if applicable): <input type="checkbox"/> Full-time student <input type="checkbox"/> Disabled If disabled, indicate reason:			
2 Dependent last name:	First name:	MI:	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male
Social Security Number:	Date of birth (MM/DD/YYYY):	Relationship: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:	
Dependent status (if applicable): <input type="checkbox"/> Full-time student <input type="checkbox"/> Disabled If disabled, indicate reason:			

3 Dependent last name:	First name:	MI:	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male
Social Security Number:	Date of birth (MM/DD/YYYY):	Relationship: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:	
Dependent status (if applicable): <input type="checkbox"/> Full-time student <input type="checkbox"/> Disabled If disabled, indicate reason:			

4 Dependent last name:	First name:	MI:	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male
Social Security Number:	Date of birth (MM/DD/YYYY):	Relationship: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:	
Dependent status (if applicable): <input type="checkbox"/> Full-time student <input type="checkbox"/> Disabled If disabled, indicate reason:			

Use the following alternate address for these dependents: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4			
Street address:			
Apt / Suite / PO box number:			
City:	State:	ZIP code:	County:

DENTAL

Coverage type: <input type="checkbox"/> Employee // Individual only <input type="checkbox"/> Employee // Individual & spouse <input type="checkbox"/> Employee // Individual & child(ren) <input type="checkbox"/> Family <input type="checkbox"/> Other	Office use only: Group #: _____ Benefit #: _____ Class/Div #: _____		
Plan name:			
Within the past 12 months, have you or any covered family individual had any dental or orthodontia coverage, such as a spouse's dental coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list all: (This section must be completed for Humana to process any dental claims)			
Current dental carrier name:	Orthodontia coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Starting date (MM/DD/YYYY):	End date, if applicable (MM/DD/YYYY):
Coverage Type (check all that apply) <input type="checkbox"/> Employee / Individual <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)			
Prior dental carrier name:	Orthodontia coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Starting date (MM/DD/YYYY):	End date, if applicable (MM/DD/YYYY):
Coverage Type (check all that apply)	<input type="checkbox"/> Employee / Individual only <input type="checkbox"/> Employee / Individual and spouse <input type="checkbox"/> Employee / Individual and child(ren) <input type="checkbox"/> Family		

BASIC LIFE /AD&D

Do you elect basic employee / individual life coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, complete waiver section	Office use only: Group #: _____ Benefit #: _____ Class/Div #: _____		
Class (employer / group will provide you with this information if needed):			
Do you elect basic dependent life? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, complete waiver section			

VOLUNTARY LIFE /AD&D

Do you elect voluntary employee / individual life coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, complete waiver section	Office use only: Group #: _____ Benefit #: _____ Class/Div #: _____
If yes, amount elected (minimum of \$15,000): _____	
Voluntary dependent life selection (available only if employee / individual elects voluntary life coverage):	
Do you elect voluntary spouse life coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, complete waiver section	
If yes, voluntary spouse life coverage (minimum of \$5,000): \$ _____	
Do you elect voluntary child(ren) life coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, complete waiver section	

VISION

Coverage type: <input type="checkbox"/> Employee // Individual only <input type="checkbox"/> Employee // Individual & spouse <input type="checkbox"/> Employee // Individual & child(ren) <input type="checkbox"/> Family <input type="checkbox"/> Other	Office use only: Group #: _____ Benefit #: _____ Class/Div #: _____
Plan name: _____	

SHORT TERM DISABILITY

Do you elect short term disability coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, complete waiver section	Office use only: Group #: _____ Benefit #: _____ Class/Div #: _____
Class (employer / group will provide you with this information if needed)	

LONG TERM DISABILITY

Do you elect long term disability coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, complete waiver section	Office use only: Group #: _____ Benefit #: _____ Class/Div #: _____
Class (employer / group will provide you with this information if needed)	

BENEFICIARY FOR LIFE AND DISABILITY BENEFITS

Primary beneficiary Last name: _____	First name: _____	MI: _____
Relationship to employee / individual: _____		
Secondary beneficiary Last name: _____	First name: _____	MI: _____
Relationship to employee / individual: _____		

EVIDENCE OF HEALTH STATUS - Do not submit more than 90 days prior to the effective date

Please complete all questions below. Omitted information will cause delays. If applying for Life coverage, please complete questions 1 thru 7. If applying for Disability coverage, please complete questions 1 thru 11.

Yes	No	
<input type="radio"/>	<input type="radio"/>	1. Is any proposed insured currently taking any prescribed medication, or do you periodically take medication for a recurrent condition?

<input type="radio"/>	<input type="radio"/>	2. In the past 12 months has any proposed insured used any tobacco or vaping product or is currently a smoker? If yes, applies to: <input type="radio"/> Employee <input type="radio"/> Spouse/Domestic Partner <input type="radio"/> Other <input type="radio"/> Child/Dependent
<input type="radio"/>	<input type="radio"/>	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?
<input type="radio"/>	<input type="radio"/>	4. Has any proposed insured been diagnosed or received treatment for an immune system disorder (i.e. Lupus, ITP), AIDS or an AIDS-related complex?
<input type="radio"/>	<input type="radio"/>	5. Has any proposed insured 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?
<input type="radio"/>	<input type="radio"/>	6. Within the past 5 years, has any proposed insured been diagnosed with diseases or disorders related to, counseled, consulted, or treated by a doctor, including surgery, for any of the following:
<input type="radio"/>	<input type="radio"/>	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)?
<input type="radio"/>	<input type="radio"/>	b. Diabetes; liver or thyroid disease; hepatitis; cirrhosis; or enlargement of the lymph nodes?
<input type="radio"/>	<input type="radio"/>	c. Stroke; Transient Ischemic Attack (TIA)?
<input type="radio"/>	<input type="radio"/>	d. Stomach, gall bladder, digestive, intestinal, or colon disorders?
<input type="radio"/>	<input type="radio"/>	e. Rheumatoid arthritis; or back disorders; or joint disorders?
<input type="radio"/>	<input type="radio"/>	f. Emphysema; asthma, or other disease of lungs, or respiratory organs?
<input type="radio"/>	<input type="radio"/>	g. Paralysis, or any other physical impairment or deformity?
<input type="radio"/>	<input type="radio"/>	h. End stage renal disease; disease of kidney?
<input type="radio"/>	<input type="radio"/>	i. Chronic Fatigue Syndrome/Fibromyalgia?
<input type="radio"/>	<input type="radio"/>	j. Kidney stones; bladder?
<input type="radio"/>	<input type="radio"/>	k. 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?
<input type="radio"/>	<input type="radio"/>	l. Cancer, and/or cancerous tumor; including skin cancer?
<input type="radio"/>	<input type="radio"/>	7. Within the past 5 years, has any proposed insured seen a health care provider or specialist for any reason not previously disclosed?

If applying for Disability coverage, please complete the following additional questions.

Please complete all questions below. Omitted information will cause delays. Do not complete if only applying for Life coverage.

Yes	No	
<input type="radio"/>	<input type="radio"/>	8. In the past 5 years, have you been treated for any disorder or condition of the back, neck, spine; arthritis; or any muscular skeletal disorder or condition?
<input type="radio"/>	<input type="radio"/>	9. Are you currently pregnant?
<input type="radio"/>	<input type="radio"/>	10. In the past 5 years, have you been diagnosed with or treated for psychotic, psychiatric, personality, or bi-polar disorder?
<input type="radio"/>	<input type="radio"/>	11. Within the past 5 years, have you been diagnosed with diseases or disorders related to, counseled, consulted, or treated by a doctor, including surgery, for any of the following: <ul style="list-style-type: none"> • circulatory or respiratory disease or disorder; • chronic obstructive pulmonary disease (COPD), sleep apnea; • heart disease, heart attack; • disease or disorder of the pancreas, or genitourinary system; • alcoholism; drug addiction, mental or nervous disorder; • Multiple sclerosis, epilepsy, seizure; • Chronic pain; • Colitis, Crohn's disease, gastric bypass or bariatric surgery; • Muscular Dystrophy; • Amyotrophic Lateral Sclerosis (ALS) or Multiple Sclerosis (MS); • Alzheimer's or Parkinson's Disease; • Major Organ Transplant; or • Narcolepsy.

If you answered “yes” to any of the questions above, please provide details below and specify the question number. Attach additional signed and dated sheets, if necessary.

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

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

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

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

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

Question #	Person treated (Last name, First name)	
Condition	Treatments received	
Medications prescribed	Upcoming 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 below is evidence of this action.

<p>I hereby waive coverage for (check all that apply):</p> <p>Dental for: <input type="checkbox"/> Myself <input type="checkbox"/> My spouse <input type="checkbox"/> My dependent child(ren)</p> <p>Basic Life for: <input type="checkbox"/> Myself <input type="checkbox"/> My spouse <input type="checkbox"/> My dependent child(ren)</p> <p>Vision for: <input type="checkbox"/> Myself <input type="checkbox"/> My spouse <input type="checkbox"/> My dependent child(ren)</p> <p>Short Term Disability for: <input type="checkbox"/> Myself</p> <p>Long Term Disability for: <input type="checkbox"/> Myself</p>	<p>I decline to apply for group coverage because of:</p> <p><input type="checkbox"/> Spousal coverage</p> <p><input type="checkbox"/> Medicare supplement</p> <p><input type="checkbox"/> Individual coverage</p> <p><input type="checkbox"/> Coverage under another carrier’s plan provided by my employer / group</p> <p><input type="checkbox"/> Other: _____</p>
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AGREEMENT

True and Complete Knowledge. I understand, agree, and represent:

- I have read the 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 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 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 Group Employee 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 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 Group Employee Enrollment Form by Humana.
- Any misrepresentation on this application may be used by Humana during the first 2 policy years to void the contract or modify the terms of the agreement.

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.

Authorization for Release of Medical Records for Life or Disability

I authorize any physician, medical or health care practitioner, hospital, clinic, veterans administration facility, other medical or medically-related facility, third party administrator, pharmacy, pharmacy benefit manager, insurance, HMO, or reinsuring company, and the Medical Information Bureau, Inc., having information regarding myself, including information concerning, advice, diagnosis, treatment and care of the physical, mental or emotional conditions, drug, substance or alcohol abuse, illness (and copies of all hospital or medical records, non-public personal health information, and any other nonmedical information), and prescription drug history to share any and all such information with Humana, or its reinsurer, or its legal representatives, and its affiliates for purposes of business improvement and development.

I understand and agree:

- Although Humana is required to inform me that any health information obtained will not be redisclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules, any information obtained will not be released by Humana to any person or organization.
- A copy of this authorization is available to me or my legal representative upon written request.
- This authorization shall be valid for two years from the date shown below.

You have the right to revoke this authorization at any time by sending written notice Humana's Privacy Office. The revocation will become effective after it is received by us but will not apply to information that has already been released in response to this authorization.

The 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 any group coverage

Signature: _____ Date: _____

Name and relationship of legal representative _____
(if a covered dependent)

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