Group Employee Enrollment Form (all group sizes)

Humana®

MINNESOTA

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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".

☐ Life plans insured or administered by Humana Insurance Company.
☐ Dental plans insured or administered by Humana Insurance Company.
☐ Vision plans insured or administered by Humana Insurance Company.
☐ 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**
☐ New business enrollment	☐ Open Enrollment event	Qualifying event date (MM/DD/YYYY)
☐ New hire/Newly eligible	☐ Rehire/Reinstatement	
☐ Dependent birth or adoption	☐ Marital status change	Benefit effective date (MM/DD/YYYY)
☐ Loss of coverage	☐ Other_____	

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

Last name:	First name:	MI:
Social Security Number (requested, but not required):	Date of birth (MM/DD/YYYY):	Phone number:
Street address:		
Apt / Suite / PO box number:	Gender: ☐ Female ☐ Male	Language of choice: ☐ English ☐ Spanish
City:	State:	ZIP code: / County:
Email address:		
Are you actively at work? ☐ Yes ☐ No If not, reason: ☐ Retiree ☐ COBRA Other: _____	Date of full-time hire (MM/DD/YYYY):	
Do you have a disability that affects your ability to communicate or read? ☐ No ☐ Yes Are you disabled or unable to perform normal work activities? ☐ No ☐ 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: ☐ Female ☐ Male
Social Security Number (requested, but not required):	Date of birth (MM/DD/YYYY):	Relationship: ☐ Spouse ☐ Child ☐ Other:	
Dependent status (if applicable): ☐ Full-time student ☐ Disabled If disabled, indicate reason:			

2 Dependent last name:	First name:	MI:	Gender: ☐ Female ☐ Male
Social Security Number (requested, but not required):	Date of birth (MM/DD/YYYY):	Relationship: ☐ Spouse ☐ Child ☐ Other:	
Dependent status (if applicable): ☐ Full-time student ☐ Disabled If disabled, indicate reason:			

3 Dependent last name:	First name:	MI:	Gender: ☐ Female ☐ Male
Social Security Number (requested, but not required):	Date of birth (MM/DD/YYYY):	Relationship: ☐ Spouse ☐ Child ☐ Other:	
Dependent status (if applicable): ☐ Full-time student ☐ Disabled If disabled, indicate reason:			

4 Dependent last name:	First name:	MI:	Gender: ☐ Female ☐ Male
Social Security Number (requested, but not required):	Date of birth (MM/DD/YYYY):	Relationship: ☐ Spouse ☐ Child ☐ Other:	
Dependent status (if applicable): ☐ Full-time student ☐ Disabled If disabled, indicate reason:			

Use the following alternate address for these dependents: ☐ 1 ☐ 2 ☐ 3 ☐ 4			
Street address:			
Apt / Suite / PO box number:			
City:	State:	ZIP code:	County:

DENTAL

Coverage type: ☐ Employee / Individual only ☐ Employee / Individual & spouse ☐ Employee / Individual & child(ren) ☐ Family ☐ 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? ☐ Yes ☐ No If yes, list all: (This section must be completed for Humana to process any dental claims)

Current dental carrier name:	Orthodontia coverage? ☐ Yes ☐ No	Starting date (MM/DD/YYYY):	End date, if applicable (MM/DD/YYYY):
Coverage Type (check all that apply) ☐ Employee / Individual ☐ Spouse ☐ Child(ren)			
Prior dental carrier name:	Orthodontia coverage? ☐ Yes ☐ No	Starting date (MM/DD/YYYY):	End date, if applicable (MM/DD/YYYY):
Coverage Type (check all that apply)	☐ Employee / Individual only ☐ Employee / Individual and spouse ☐ Employee / Individual and child(ren) ☐ Family		

BASIC LIFE /AD&D

Do you elect basic employee / individual life coverage? ☐ Yes ☐ 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? ☐ Yes ☐ No If no, complete waiver section	

VOLUNTARY LIFE /AD&D

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

VISION

Coverage type: ☐ Employee / Individual only ☐ Employee / Individual & spouse ☐ Employee / Individual & child(ren) ☐ Family ☐ Other	**Office use only:** Group #: Benefit #: Class/Div #:
Plan name:	

SHORT TERM DISABILITY

Do you elect short term disability coverage? ☐ Yes ☐ 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? ☐ Yes ☐ 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		
❍	❍	1.	Is any proposed insured currently taking any prescribed medication, or do you periodically take medication for a recurrent condition?

❍	❍	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: ❍ Employee ❍ Spouse/Domestic Partner ❍ Other ❍ Child/Dependent
❍	❍	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?
❍	❍	4.	Has any proposed insured been diagnosed with, or received treatment or care from a medical professional for an immune system disorder (i.e. Lupus, ITP), AIDS or an AIDS-related complex?
❍	❍	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?
		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:
❍	❍	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)?
❍	❍	b.	Diabetes; liver or thyroid disease; hepatitis; cirrhosis; or enlargement of the lymph nodes?
❍	❍	c.	Stroke; Transient Ischemic Attack (TIA)?
❍	❍	d.	Stomach, gall bladder, digestive, intestinal, or colon disorders?
❍	❍	e.	Rheumatoid arthritis; or back disorders; or joint disorders?
❍	❍	f.	Emphysema; asthma, or other disease of lungs, or respiratory organs?
❍	❍	g.	Paralysis, or any other physical impairment or deformity?
❍	❍	h.	End stage renal disease; disease of kidney?
❍	❍	i.	Chronic Fatigue Syndrome/Fibromyalgia?
❍	❍	j.	Kidney stones; bladder?
❍	❍	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?
❍	❍	l.	Cancer, and/or cancerous tumor; including skin cancer?
❍	❍	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		
❍	❍	8.	In the past 5 years, have you been diagnosed with, or received treatment or care from a medical professional for any disorder or condition of the back, neck, spine; arthritis; or any muscular skeletal disorder or condition?
❍	❍	9.	Are you currently pregnant?
❍	❍	10.	In the past 5 years, have you been diagnosed with, or received treatment or care from a medical professional for psychotic, psychiatric, personality, or bi-polar disorder?
❍	❍	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: • 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.

I hereby waive coverage for (check all that apply):		I decline to apply for group coverage because of:
Dental for:	☐ Myself ☐ My spouse ☐ My dependent child(ren)	☐ Spousal coverage
Basic Life for:	☐ Myself ☐ My spouse ☐ My dependent child(ren)	☐ Medicare supplement
Vision for:	☐ Myself ☐ My spouse ☐ My dependent child(ren)	☐ Individual coverage
Short Term Disability for:	☐ Myself	☐ Coverage under another carrier's plan provided by my employer / group
Long Term Disability for:	☐ Myself	☐ Other:_________________________

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. Note: We request notification of birth or adoption, however, newborn children will be covered from the moment of birth and adopted children will be covered from the date of placement for adoption.
- 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.
- If I have elected Life or Disability coverage, I may be required to furnish evidence of health status satisfactory to Humana when the coverage amount is above the guarantee issue amount, or if I'm a late enrollee.
- 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 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.
- 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.
- A person who submits an application or files a claim with intent to defraud or help commit a fraud against an insurer is guilty of a crime.

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 as long as I am continually insured by Humana or until revoked.

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.)

AGENT / PRODUCER INFORMATION

Agency of Record (for commissions and correspondence)	**Agent/Agency of Record** (for split commissions)
Name (print or type)	Name (print or type)
Tax ID Number/Humana Agent Number	Tax ID Number/Humana Agent Number
Commission split ☐ No ☐ Yes If yes, percentage: _____ (equals 100%)	Commission split ☐ No ☐ Yes If yes, percentage: _____ (equals 100%)
Writing Agent/Broker Producer	**Agent/Agency of Record**
Name (print or type)	Name (print or type)
Tax ID/Humana Agent Number	Tax ID/Humana Agent Number
Commission split ☐ No ☐ Yes If yes, percentage: _____ (equals 100%)	Commission split ☐ No ☐ Yes If yes, percentage: _____ (equals 100%)

General Agency (Complete only if agency involved in sale)

General agency information pertains to: ☐ Agency of Record ☐ Writing Agent	
Name (print or type)	Tax ID/Humana Agent Number

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 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 _____

MINNESOTA DISCLOSURE OF ACCELERATED BENEFITS

If a covered employee is diagnosed with a Terminal Condition, the employee may request that an accelerated benefit be paid immediately. The Employee Group Term Life Insurance has no cash surrender or loan values. The amount payable is 50% to a maximum benefit of $250,000 in the present value, including net cash surrender and net cash withdrawal values.

PAYMENT FROM THIS BENEFIT MAY BE TAXABLE. ASSISTANCE SHOULD BE SOUGHT FROM YOUR PERSONAL TAX ADVISOR. WE ARE NOT RESPONSIBLE FOR ANY TAX OR OTHER EFFECTS FROM AN ACCELERATED BENEFIT PAYMENT OR LOSS OF ELIGIBILITY FOR ANY STATE OR FEDERAL PROGRAM.

EFFECT ON DEATH BENEFIT

Payment of this benefit does not guarantee that the employee's full death benefit will eventually be paid. The employee must still be insured under the Policy at the time of death for the remainder of the Term Life Insurance benefit to be paid.

The amount of Term Life Insurance payable to the beneficiary at the time of death will be reduced by any Accelerated Death Benefit amount paid. The remaining Term Life Insurance amount will be paid according to the terms and provisions of the Policy. Any amount you could otherwise convert will also be reduced by the Accelerated Death Benefit.

DEFINITIONS

Terminal Condition means a **Sickness** or **Bodily Injury** which is diagnosed by a **Qualified Practitioner** which:

1. Is life-threatening with a life expectancy of 24 months or less;
2. Requires the **Employee** to be continuously confined in a **Qualified Treatment Facility** for the rest of his or her life; or
3. Requires extraordinary medical intervention, without which the Employee's life span would be drastically limited or he or she would not live, such conditions may include, but are not limited to:
   A. Coronary artery disease resulting in acute infarction;
   B. Coronary artery surgery;
   C. Permanent neurological deficit resulting from cerebral vascular accident;
   D. End Stage Renal failure; or
   E. Acquired Immune Deficiency Syndrome (AIDS)

QUALIFICATIONS FOR ACCELERATED BENEFITS

The Accelerated Death Benefit provision is effective for a Terminal Illness or Qualified Covered Condition:

1. On the effective date of this Policy for a **Bodily Injury**: or
2. Thirty (30) days following the effective date of this Policy for a **Sickness**.

To qualify for the Accelerated Death Benefit the covered employee must:

1. Provide proof of a Terminal Illness acceptable to us;
2. Request this benefit in writing on a form acceptable by us; and
3. Provide written consent stating assignee or irrevocable beneficiary has agreed to payment of the Accelerated Death Benefit on the employee's behalf.

PLEASE REFER TO THE ACCELERATED DEATH BENEFITS PROVISION OF YOUR CERTIFICATE OF INSURANCE TO DETERMINE THE SPECIFIC TERMS AND CONDITIONS OF THIS BENEFIT.