Group Employee Enrollment Form (all group sizes)

Humana®

OREGON

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, Disability, and Life 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:	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 /domestic partner.

1 Dependent last name:	First name:	MI:	Gender: ☐ Female ☐ Male
Social Security Number:	Date of birth (MM/DD/YYYY):	Relationship: ☐ Spouse /Domestic Partner ☐ 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:	Date of birth (MM/DD/YYYY):	Relationship: ☐ Spouse /Domestic Partner ☐ 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:	Date of birth (MM/DD/YYYY):	Relationship: ☐ Spouse /Domestic Partner ☐ 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:	Date of birth (MM/DD/YYYY):	Relationship: ☐ Spouse /Domestic Partner ☐ 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

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

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 /domestic partner life coverage? ☐ Yes ☐ No If no, complete waiver section If yes, voluntary spouse /domestic partner 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.	Within the past 10 years, has any proposed insured been diagnosed or received treatment 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 treated 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 treated 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 /domestic partner ☐ My dependent child(ren)	☐ Spousal coverage
Basic Life for:	☐ Myself ☐ My spouse /domestic partner ☐ My dependent child(ren)	☐ Medicare supplement ☐ Individual coverage
Vision for:	☐ Myself ☐ My spouse /domestic partner ☐ My dependent child(ren)	☐ Coverage under another carrier’s plan provided by my employer / group
Short Term Disability for:	☐ Myself	☐ Other:_________________________
Long Term Disability for:	☐ Myself	

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 /domestic partner) 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 /domestic partner) 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 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 /domestic partner) 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.
- 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.
- Domestic partnership contracts between individuals of the same sex must be allowed the same privileges, immunities, rights, and benefits granted by law to married individuals. Such rights are extended to include children of partners, as well as children of former or surviving partners.
- Incontestability: After you have been insured under the policy for two years, we cannot contest the validity of coverage except for nonpayment of premium.
- Any person who knowingly and with the intent to defraud an insurer submits an application for insurance or files a claim containing any materially false 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 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 Coverage

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, and non-public personal health 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:

• The personal information collected under 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.

• 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.

• A photographic copy of this authorization shall be as valid as the original.

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) _____