

Humana Employee Enrollment Form - Specialty Benefits

COLORADO

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in this application as "Humana". To elect primary care physician or dentist, please complete reorder GN-51340-PP.

Medical and Life plans insured or administered by Humana Insurance Company. HMO plans offered or administered by Humana Health Plan, Inc. or offered or administered by Humana Health Plan, Inc. and insured or administered by Humana Insurance Company. Dental plans insured or administered by HumanaDental Insurance Company or Humana Insurance Company. Dental Discount Plans administered by CompBenefits Direct, Inc. Alpha Dental Plan insured and administered by Beta Health Association, Inc. Vision plans insured or administered by CompBenefits Insurance Company or HumanaDental Insurance Company or Humana Insurance Company.

Please print clearly and fill in each applicable circle.

Proposed effective date: ___/___/_____

Company name	Company city	State
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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	Height (ft / in)	Weight (lbs.)	Gender	Full-time student?	Date of birth	Disabled? If yes, indicate reason and SSN within the field below.
Employee		/		<input type="radio"/> F <input type="radio"/> M	N/A	___/___/_____	<input type="radio"/> N Reason: <input type="radio"/> Y SSN: <small>N/A - complete in Employee Information section.</small>
Spouse		/		<input type="radio"/> F <input type="radio"/> M	N/A	___/___/_____	<input type="radio"/> N Reason: <input type="radio"/> Y SSN:
Child		/		<input type="radio"/> F <input type="radio"/> M	<input type="radio"/> N <input type="radio"/> Y	___/___/_____	<input type="radio"/> N Reason: <input type="radio"/> Y SSN:
Child		/		<input type="radio"/> F <input type="radio"/> M	<input type="radio"/> N <input type="radio"/> Y	___/___/_____	<input type="radio"/> N Reason: <input type="radio"/> Y SSN:
Child		/		<input type="radio"/> F <input type="radio"/> M	<input type="radio"/> N <input type="radio"/> Y	___/___/_____	<input type="radio"/> N Reason: <input type="radio"/> Y SSN:
Other (specify):		/		<input type="radio"/> F <input type="radio"/> M	<input type="radio"/> N <input type="radio"/> Y	___/___/_____	<input type="radio"/> N Reason: <input type="radio"/> Y SSN:

EMPLOYEE INFORMATION:	HOURS WORKED PER WEEK:	<input type="radio"/> RETIREE	DATE OF FULL-TIME HIRE: ___/___/_____
SSN #	Street address	APT / Suite / Box	
City	State	ZIP code	Phone # ()
Language: <input type="radio"/> English <input type="radio"/> Spanish	E-mail address	Occupation	

Dental	Group #: _____	Benefit #: _____	Class/Div: _____
Coverage type:	<input type="radio"/> Employee only <input type="radio"/> Employee and spouse <input type="radio"/> Employee and child(ren) <input type="radio"/> Family <input type="radio"/> NO COVERAGE (complete waiver)		Plan name
Prior dental coverage during the past 12 months (individual or other group coverage)? <input type="radio"/> N <input type="radio"/> Y			
Prior dental insurance carrier name	Prior coverage type: <input type="radio"/> Employee only <input type="radio"/> Employee and spouse <input type="radio"/> Employee and child(ren) <input type="radio"/> Family	Effective date ___/___/_____	Policy #
Prior orthodontia coverage in the past 12 months? <input type="radio"/> N <input type="radio"/> Y		Term date ___/___/_____	Prior carrier phone # ()

Basic Life	Group #: _____	Benefit #: _____	Class/Div: _____
Primary beneficiary name (Last, First MI)		Secondary beneficiary name (Last, First MI)	
Class (employer will provide you with this information if needed)	Annual salary (if applicable) \$	Basic dependent life? <input type="radio"/> N <input type="radio"/> Y If no, complete waiver section.	

Voluntary Life	Group #: _____	Benefit #: _____	Class/Div: _____
Voluntary employee life coverage? <input type="radio"/> N <input type="radio"/> Y	Amount (min \$15,000) \$	Primary beneficiary name (Last, First MI)	Secondary beneficiary name (Last, First MI)
Voluntary spouse life coverage? <input type="radio"/> N <input type="radio"/> Y	Amount (min. \$5,000) \$	Voluntary child(ren) life coverage? <input type="radio"/> N <input type="radio"/> Y	Annual employee salary (if applicable) \$

Vision	Group #: _____	Benefit #: _____	Class/Div: _____
Coverage type:	<input type="radio"/> Employee only <input type="radio"/> Employee and spouse <input type="radio"/> Employee and child(ren) <input type="radio"/> Family <input type="radio"/> NO COVERAGE (complete waiver)		Plan name

Last name:

First 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. I proclaim that I was not pressured or forced by my employer, 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.

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

True and complete acknowledgement

- I understand, agree and represent:
- I have read this document 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 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 this application for coverage is accepted, coverage will be effective on the date specified by Humana on the certificate of coverage/certificate of insurance.
- 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 becomes eligible for premium 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. I understand eligibility for enrollment does not apply to a High Deductible Health Plan (HDHP).
- In the event that I should decide to apply for coverage hereafter, that subsequent application shall be subject to the applicable terms and conditions of the master group contract(s) or certificate provisions which may require additional limitations and waiting periods.
- I may be required to furnish, at my own expense, 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. I understand eligibility for enrollment does not apply to a HDHP.
- 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 application for coverage.
- 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 for the purposes of depositing any contributions.
- Any misrepresentation contained herein relied on by Humana may be used to reduce or deny a claims or void the contract within the contestable period if such misrepresentation materially affected the acceptance of the risk.
- 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 this application.
- 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.
- It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

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 an application, 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 document, together with any supplements, will form part of any contract and be the basis for any certificate of coverage/ certificate of insurance issued.

Last name: _____

First name: _____

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 or legal representative signature: _____ Date: _____

Name and relationship of legal representative: _____

Spouse signature: _____ Date: _____

(Only if selecting Life coverage over the guarantee issue amount.)