

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in this application as "Humana." Life and Short Term income protection plans insured or administered by Humana Insurance Company. PPO, EPO and Indemnity plans offered by Humana Health Insurance Company of Florida, Inc. HMO plans offered by Humana Medical Plan, Inc. Prepaid, Basic, Intermediate and High Dental plans underwritten by The Dental Concern, Inc. Prepaid Capitol II and Universal II Dental plans provided by SafeGuard Health Plans, Inc. All other Dental plans insured or administered by HumanaDental Insurance Company or Humana Insurance Company.

Medical Group number

Benefit number

Class/Division

Please print clearly.

Company name

Proposed Effective Date

Company city State

MMDDYYYY

**Employee information** FL-80124-GN

Last name First name MI

Social Security number Date of birth Phone number

Gender:  Female  Male E-mail address

Street address Apt / Suite / PO box number

City State Zip code County

Language of choice:  English  Spanish

Employment status:  Full-time employee: number of hours worked per week Date of full-time hire

Are you disabled or unable to perform normal activities?  No  Yes If yes, indicate reason

**Dependent information** FL-80124-DP

Please enter information for each dependent, including spouse, applying for coverage. For additional dependents, copy and attach an additional Dependent Information form.

1. Last name First name MI Date of birth

Social Security number Gender:  Female  Male Relationship:  Spouse  Child  Other:

Dependent status (if applicable):  Full-time student  Disabled If disabled, indicate reason

**HMO and POS only: (Not Applicable for HumanaAccess HMO)**

Primary care physician Physician ID Current patient:  No  Yes

**Prepaid:** Network name

Dentist name Facility number Current patient?  No  Yes

2. Last name First name MI Date of birth

Social Security number Gender:  Female  Male Relationship:  Spouse  Child  Other:

Dependent status (if applicable):  Full-time student  Disabled If disabled, indicate reason

**HMO and POS only: (Not Applicable for HumanaAccess HMO)**

Primary care physician Physician ID Current patient:  No  Yes

**Prepaid:** Network name

Dentist name Facility number Current patient?  No  Yes

3. Last name First name MI Date of birth

Social Security number Gender:  Female  Male Relationship:  Spouse  Child  Other:

Dependent status (if applicable):  Full-time student  Disabled If disabled, indicate reason

**HMO and POS only: (Not Applicable for HumanaAccess HMO)**

Primary care physician Physician ID Current patient:  No  Yes

**Prepaid:** Network name

Dentist name Facility number Current patient?  No  Yes

Group number

Social Security number

**Medical** FL-80124-SG

Coverage type:  Employee only  Employee and spouse  Employee and child(ren)  Family  Other

Plan name Network name

**HMO and POS only:**

Employee primary care physician Physician ID Current patient:  No  Yes

**Concurrent medical coverage:**

Will you have any other group medical coverage, including Medicare, in effect at the same time as this Humana coverage?  No  Yes

Medical carrier name Policy number

Carrier phone number Medicare ID Effective date Term date

Coverage type:  Employee only  Employee and spouse  Employee and child(ren)  Family

**Prior medical coverage: (This section must be completed in order for Humana to process any medical claims.)**

Within the past 18 months, have you had any individual or other group medical coverage, including Medicare?  No  Yes

Prior medical carrier name Policy number

Prior carrier phone number Medicare ID Effective date Term date

Prior coverage type:  Employee only  Employee and spouse  Employee and child(ren)  Family Still in effect?  No  Yes

**Dental** FL-80124-HD

Group number	Benefit number	Class/Division

Coverage type:  Employee only  Employee and spouse  Employee and child(ren)  Family  Other

Plan name Network name

**Prepaid:**

Dentist name Facility number Current patient?  No  Yes

Within the past 12 months, have you had any individual or other group dental coverage?  No  Yes Orthodontia coverage?  No  Yes

Effective date Term date Prior coverage type:  Employee only  Employee & spouse  Employee & child(ren)  Family

**Basic Life** FL-80124-HL

Group number	Benefit number	Class/Division

Primary beneficiary name

Secondary beneficiary name

Class (employer will provide you with this information if needed) Annual salary (if applicable) \$

**Basic dependent life:**  No  Yes If no, complete waiver section

**Voluntary Life**

Do you elect voluntary employee life coverage?  No  Yes Amount (minimum of \$15,000) \$ Annual salary \$

Primary beneficiary name

Secondary beneficiary name

**Voluntary dependent life** (available only if employee elects voluntary life coverage) Do you elect voluntary child(ren) life coverage?  No  Yes

Do you elect voluntary spouse life coverage?  No  Yes Amount (minimum of \$5,000) \$

**Short-term income protection** FL-80124-SD

Do you elect short-term income protection coverage?  No  Yes Annual salary \$

Class (employer will provide if needed)

**Health savings account** FL-80124-HA

Group number	Benefit number	Class/Division

*If you have medical coverage under another plan, you may not be eligible for an HSA. Please check with your tax advisor for details.*

Do you elect the health savings account?  No  Yes

**For help filling out this section, use the enrollment application HSA worksheet.**

- ▶ 1 How much were you allowed to contribute to any HSA in this calendar year to date? \$
- ▶ 2 How much have you contributed to any HSA in this calendar year-to-date? \$
- ▶ 3 How much do you wish to contribute to the HSA for the remainder of this calendar year? \$

Group number

Social Security number

**Health savings account (continued)**

- 4 If your plan year spans two calendar years, how much are you allowed to contribute to your HSA for the portion of the plan year that falls in the second calendar year? \$
- 5 How much have you already contributed to any HSA for the portion of your plan year that falls in the second calendar year? \$
- 6 How much do you wish to contribute to your HSA for the portion of your plan year that falls in the second calendar year? \$
- 7 Please provide the effective date of this HSA information (mm/01/yyyy) / 01 /

Beneficiary for this account will be the employee's estate. You may change beneficiary information on file with the bank that administers the HSA once the account is established.

**Evidence of health status** FL-80124-HS

**This information should not be submitted more than 60 days prior to the effective date.**

Complete this section for employees and dependents enrolling for medical coverage who are members of groups with 1-9 applicants and applicants requesting Life insurance over the guarantee issue amount, and all late enrollees applying for Short-term income protection or Life coverage.

- 1. Are you or any dependent currently under any treatment or prescribed medications?  No  Yes
- 2. Have you or any dependent had unexplained weight loss or fatigue in the past 12 months?  No  Yes
- 3. Have you or any dependent ever had, been diagnosed with, counseled, consulted or treated for any of the following within the past 5 years:
  - a. Chest pain; disease of heart, arteries or blood vessels; high or low blood pressure?  No  Yes
  - b. Nervous, mental or emotional disorder; convulsions; epilepsy; unconsciousness?  No  Yes
  - c. Asthma or other disease of lungs or respiratory organs?  No  Yes
  - d. Kidney stones; disease of kidney, bladder, male or female organs; or infertility?  No  Yes
  - e. Cancer, and/or cancerous tumor? (state type; part of body)  No  Yes
  - f. Diabetes; liver or thyroid disease; or enlargement of the lymph nodes?  No  Yes
  - g. Stomach, gall bladder, intestinal or colon disorders?  No  Yes
  - h. Rheumatoid arthritis or back disorders?  No  Yes
  - i. Phlebitis, paralysis, or any other physical impairment or deformity?  No  Yes
  - j. Alcoholism or drug habit, or been a member of Alcoholics Anonymous?  No  Yes
- 4. Have you or any dependent been tested positive for exposure to HIV infection or been diagnosed as having AIDS-related complex or AIDS caused by the HIV infection or other sickness or condition derived from such infections within the past 5 years?  No  Yes
- 5. Have you or any dependent been hospitalized or had hospitalization advised, had surgery or been advised to have surgery, had any injury, illness, medical attention or medical advice or treatment during the past 5 years for any reason not already mentioned?  No  Yes
- 6. Are you or any dependent pregnant or ever had a cesarean section?  No  Yes
- 7. Please provide height/weight information for all applicants enrolling for coverage:

	Height (ft / in)	Weight
a. Employee name		
b. Spouse name		
c. Dependent name		
d. Dependent name		
e. Dependent name		

**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 number \_\_\_\_\_ Person treated last name \_\_\_\_\_ First name \_\_\_\_\_

Condition \_\_\_\_\_

List symptoms encountered \_\_\_\_\_

List treatments received \_\_\_\_\_

List medical tests administered \_\_\_\_\_

Medication(s) if any \_\_\_\_\_

Date condition was first diagnosed \_\_\_\_\_ Date last seen by a doctor for this condition \_\_\_\_\_

Group number

Social Security number

**Waiver (refusal of coverage)** FL-80124-SG

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 below is evidence of this action. 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

Short-term Income Protection for:  Myself

I decline to apply for group coverage because of (check all that apply):  Spousal coverage  Medicare supplement  
 Individual coverage  Coverage under another carrier's plan provided by my employer  Other:

- I understand and agree:
- In the event that I should decide to apply for such coverage hereafter, that such subsequent application shall be subject to the applicable terms and conditions of the master group contract(s) or plan provisions as described in the Summary Plan Description 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 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.
  - If I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents provided that I request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.
  - Humana reserves the right to delay medical coverage and/or deny life or dental coverage with any future application for coverage.

**Agreement** FL-80124-AA

**True and complete acknowledgement**

I understand, agree and represent:

- I have read this document or it has been read to me.
- The answers provided within this entire application for coverage are to the best of my knowledge and belief, true and complete.
- Neither my employer nor the agent has the authority to waive a complete answer to 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.
- Any misrepresentation contained herein relied on by Humana may be used to reduce or deny a claim or void the contract within the contestable period if such misrepresentation materially affected the acceptance of the risk.
- 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.

I hereby enroll for benefits for which I am presently eligible or for which I may become eligible under my employer's group contract(s). If any deductions are required for this coverage, I authorize such deductions from my earnings. I reserve the right to revoke this deduction authorization at any time upon written notice unless I have chosen to use pretax deductions.

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.

**Authorization**

My dependents and I authorize any physician, medical practitioner, hospital, clinic, veterans administration facility, other medical or medically-related facility, Pharmacy Benefit Manager, insurance, HMO or reinsuring company, the Medical Information Bureau, Inc., or the Consumer Reporting Agency having information regarding myself and my dependents, including information concerning, advice, diagnosis, treatment and care of physical, psychiatric, mental or emotional conditions, drug, substance or alcohol abuse or illness, and any other non-medical information, to give any and all such information to Humana or their legal representative.

My dependents and I understand and agree:

- The information obtained by use of this authorization may be used by Humana to 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 any application, claim or as may be otherwise lawfully required, or as we may further authorize.
- We may request to receive a copy of this authorization.
- A photographic copy of this authorization shall be as valid as the original.
- This authorization shall be valid for two years from the date shown below.

**Signature—please sign below if enrolling or waiving group coverage**

Employee signature \_\_\_\_\_ Date \_\_\_\_\_

Spouse signature \_\_\_\_\_ Date \_\_\_\_\_  
(If covered dependent)