Print Form

Visit us at www.humana.com or www.humanadental.com

Humana Employee Enrollment Form - 2-99 Employees TEXAS

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in this application as "Humana".

PPO and Classic Medical plans, Life and Vision plans insured or administered by Humana Insurance Company. HMO plans offered by Humana Health Plan of Texas, Inc., a Health Maintenance Organization. POS plans offered by Humana Health Plan of Texas, Inc., a Health Maintenance Organization and insured or administered by Humana Insurance Company. Prepaid and AdvantagePlus dental benefits offered and administered by DentiCare, Inc. (d/b/a CompBenefits). All other Dental plans insured or administered by HumanaDental Insurance Company or Humana Insurance Company. CompBenefits Vision plan insured and administered by CompBenefits Insurance Company.

Please print clearly and fill in each applicable circle. Proposed Effective Date: _ _ / _ _ / _ _ _ _

Company name	Company city	State

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.
Employee		/		❍ F ❍ M	N/A	_ _ / _ _ / _ _ _ _	❍ N ❍ Y Reason:
Spouse		/		❍ F ❍ M	N/A	_ _ / _ _ / _ _ _ _	❍ N ❍ Y Reason:
Child		/		❍ F ❍ M	❍ N ❍ Y	_ _ / _ _ / _ _ _ _	❍ N ❍ Y Reason:
Child		/		❍ F ❍ M	❍ N ❍ Y	_ _ / _ _ / _ _ _ _	❍ N ❍ Y Reason:
Child		/		❍ F ❍ M	❍ N ❍ Y	_ _ / _ _ / _ _ _ _	❍ N ❍ Y Reason:
Other (specify):		/		❍ F ❍ M	❍ N ❍ Y	_ _ / _ _ / _ _ _ _	❍ N ❍ Y Reason:

EMPLOYEE INFORMATION: **HOURS WORKED PER WEEK:** ❍ **RETIREE** **DATE OF FULL-TIME HIRE:** _ _ / _ _ / _ _ _ _

SSN #	Street address	APT / Suite / Box

City	State	Zip code	Phone # ( )

Language: ❍ English ❍ Spanish Email address

Do you have a disability that affects your ability to communicate or read? ❍ N ❍ Y

TX-72000-EI 5/2008

Medical

Group #: Benefit #: Class/Div:

Coverage type: ❍ Employee only ❍ Employee and spouse ❍ Employee and child(ren) ❍ Family ❍ NO COVERAGE (complete waiver) Plan name

1. Prior medical coverage during the past 18 months (individual or other group coverage)? ❍ N ❍ Y

Prior medical insurance carrier name	Policy #	**Prior coverage type:** ❍ Employee only ❍ Employee and spouse ❍ Employee and child(ren) ❍ Family	Effective date _ _ / _ _ / _ _ _ _ Term date _ _ / _ _ / _ _ _ _

2. Other medical coverage in effect at the same time as this Humana coverage (individual or other group coverage)? ❍ N ❍ Y

Other Medical Insurance carrier name	Policy #	**Other coverage type:** ❍ Employee only ❍ Employee and spouse ❍ Employee and child(ren) ❍ Family	Effective date _ _ / _ _ / _ _ _ _ Term date _ _ / _ _ / _ _ _ _

3. Medicare coverage:

Employee coverage: ❍ N ❍ Y	Medicare ID	Effective date _ _ / _ _ / _ _ _ _	Term date _ _ / _ _ / _ _ _ _
Spouse coverage: ❍ N ❍ Y	Medicare ID	Effective date _ _ / _ _ / _ _ _ _	Term date _ _ / _ _ / _ _ _ _

TX-72000-MD 5/2008

Health Savings Account

Group #: Benefit #: Class/Div:

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

Please refer to Humana's HSA contribution worksheet to calculate your maximum allowed contribution. You can find additional information on HSAs on Humana.com. Select the Quick Link for Spending Account information on the Member page.

Do you elect the Health Savings Account? ❍ N ❍ Y (If no, complete waiver.)	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.

TX-72000-HA 5/2008

Last name:	First name:

Dental

Dental	Group #:		Benefit #:		Class/Div:	

Coverage type: ❍ Employee only ❍ Employee and spouse ❍ Employee and child(ren) ❍ Family ❍ NO COVERAGE (complete waiver)		Plan name
Prior dental coverage during the past 12 months (individual or other group coverage)? ❍ N ❍ Y		
Prior dental insurance carrier name	**Prior coverage type:** ❍ Employee only ❍ Employee and spouse ❍ Employee and child(ren) ❍ Family	Effective date _ _ / _ _ / _ _ _ _	Policy #
Prior orthodontia coverage in the past 12 months? ❍ N ❍ Y		Term date _ _ / _ _ / _ _ _ _	Prior carrier phone # ( )
TX-72000-HD 5/2008			

Basic Life

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?** ❍ No ❍ Yes If no, complete waiver section.
TX-72000-BL 5/2008		

Voluntary Life

Voluntary Life	Group #:		Benefit #:		Class/Div:	

Voluntary employee life coverage? ❍ N ❍ Y	Amount (min $15,000) $	Primary beneficiary name (Last, First MI)	Secondary beneficiary name (Last, First MI)
Voluntary spouse life coverage? ❍ N ❍ Y	Amount (min. $5,000) $	**Voluntary child(ren) life coverage?** ❍ N ❍ Y	Annual employee salary (if applicable) $
TX-72000-VL 5/2008			

Vision

Vision	Group #:		Benefit #:		Class/Div:	

Coverage type: ❍ Employee only ❍ Employee and spouse ❍ Employee and child(ren) ❍ Family ❍ NO COVERAGE (complete waiver)	Plan name
TX-72000-VS 5/2008	

Medical Health History

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

1. Within the past 24 months have you or any dependent to be covered had or been treated for an illness or injury, had surgery or hospitalization recommended, or are currently pregnant? ❍ N ❍ Y	**2.** Within the past 24 months have you or any dependent to be covered been prescribed medication? ❍ N ❍ Y	**3.** Have you or any dependent to be covered incurred medical expenses in excess of $7,500 in the past 12 months? ❍ N ❍ Y

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 # & letter	Person treated (Last name, First name)
Condition	Treatments received
Medications prescribed	Current or future treatments or medications
Date diagnosed _ _ / _ _ / _ _ _ _	Date last seen by a doctor _ _ / _ _ / _ _ _ _

Question # & letter	Person treated (Last name, First name)
Condition	Treatments received
Medications prescribed	Current or future treatments or medications
Date diagnosed _ _ / _ _ / _ _ _ _	Date last seen by a doctor _ _ / _ _ / _ _ _ _

Question # & letter	Person treated (Last name, First name)
Condition	Treatments received
Medications prescribed	Current or future treatments or medications
Date diagnosed _ _ / _ _ / _ _ _ _	Date last seen by a doctor _ _ / _ _ / _ _ _ _

TX-72000-MH 5/2008

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.

I hereby waive coverage for (check all that apply):	**I decline to apply for group coverage because of**:
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) Vision for: ❍ Myself ❍ My spouse ❍ My dependent child(ren) Health Savings Account for: ❍ Myself	❍ Spousal coverage ❍ Medicare supplement ❍ Individual coverage ❍ Coverage under another carrier's plan provided by my employer ❍ Other:

TX-72000-WV 5/2008

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 with in 31 days after the qualifying event.
- 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 plan 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. This information will be used only for rating and administrative purposes and not for purposes of eligibility for coverage.
- 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 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 intentional 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 intentional misrepresentation materially affected the acceptance of the risk.
- In the event that I should decide to apply for HMO or POS coverage hereafter, I will only be eligible at the group's open enrollment period, unless I meet one of the exceptions of the late enrollee provisions. In the event that I should decide to apply for PPO, Classic or Indemnity coverage hereafter, Humana reserves the right to impose a 12-month pre-existing limitation.
- Any intentional material false statement, misrepresentation or omission 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 intentional misrepresentation or omission materially affected the acceptance of the risk.
- For small employer groups, I understand that any misstatements of health status will not be used to cancel, non-renew or void my medical coverage under this policy or plan but may result in an increase in medical premiums following a written notice as required in the Policy or Group Contract.

Authorization

I authorize any third party to have information regarding myself and my dependents. 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.

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. 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.
- 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 and I have the right to revoke this authorization at any time by writing to Humana's Privacy Office.

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.

TX-72000-AA 5/2008

Last name: | First name:

Required Disclosure Notice for PPO & HMO Consumer Choice Benefit Plans for groups with 2-99 employees

Below is the Required Disclosure Notice for Group PPO & HMO Consumer Choice Benefit Plans Issued in Texas. To obtain a copy of the required Consumer Choice Disclosure Notice for Consumer Choice POS Benefit Plans Issued in Texas, please consult your insurance agent.

If your employer has selected the Consumer Choice PPO Benefits Health Plan, Consumer Choice HMO Benefits Health Plan or the Consumer Choice POS Benefits Health Plan, your plan in whole or in part does not provide state-mandated health benefits normally required in Texas health benefit plans.

A consumer choice standard health benefit plan may provide more affordable health benefits for you although, at the same time, it may provide you with fewer health benefits than those normally included as state-mandated health benefits in Texas health benefit plans. Please consult with your Benefit Administrator to discuss the state-mandated health benefits that are reduced and/or excluded.

Excluded PPO State Mandates	Excluded HMO State Mandates
Chemical & Alcohol Dependency	Chemical & Alcohol Dependency
TMJ	Oral Contraceptive Drugs & Devices
Home Health Care	TMJ
Serious Mental Illness	Serious Mental Illness
Invitro	Invitro
Speech & Hearing	

The Consumer Choice Health Benefit Plan may include requirements and/or restrictions on deductibles, coinsurance, copayments, or annual or lifetime maximum benefit amounts that differ from other PPO & HMO plans. I understand that I may obtain from the Department of Insurance a consumer brochure with more information on Consumer Choice Health Benefit Plans, either by visiting the TDI website at www.tdi.state.tx.us/consumer/index.html, or by calling 1-800-252-3439.

By signing this application, I acknowledge that I was offered the opportunity to apply for an accident and sickness insurance policy or evidence of coverage in the same category that most closely approximates the consumer choice health benefit plan offered.

TX-72000-NOTICE 5/2008

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: _____

TX-72000-SA 5/2008

Print Form | Reset Form