

Humana employee enrollment application—2-9 employees

KENTUCKY

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

For Humana HMO and POS medical plans in Northern KY, coverage is provided by Humana Health Plan of Ohio, Inc. For any other PPO, HMO, or POS medical plans, coverage is provided by Humana Health Plan, Inc., a Health Maintenance Organization. For Classic medical plans and Standard Indemnity medical plans, Life and Short Term Income Protection plans, insurance coverage is provided or administered by Humana Insurance Company of Kentucky. For Dental, insurance coverage is provided or administered by The Dental Concern, Inc.

Please print clearly.

Company name _____

Company city _____ State _____

Proposed Effective Date
(MMDDYYYY)

Employee information KY-80124-GN 7/2005

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 KY-80124-DP 7/2005

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:

Primary care physician _____ Physician ID _____ 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:

Primary care physician _____ Physician ID _____ 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:

Primary care physician _____ Physician ID _____ Current patient: No Yes

4. 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:

Primary care physician _____ Physician ID _____ Current patient: No Yes

Medical KY-80124-MD 7/2005

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

Group number

Social Security number

Medical (continued)

Concurrent medical coverage:

- Will you or any of your covered dependents have any other individual or other group medical coverage, including Medicare, in effect at the same time as this Humana coverage? No Yes
If yes, please complete below

Individual or other group medical coverage:

Medical carrier name

Policy number Effective date

Carrier phone number Term date

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

Medicare coverage:

Employee Coverage No Yes Effective date

Medicare ID Term date

Spouse Coverage No Yes Effective date

Medicare ID Term date

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

- Within the past 18 months, have you or any of your covered dependents had any other individual or other group medical coverage, including Medicare? No Yes If yes, please complete below

Individual or other group medical coverage:

Prior medical carrier name

Policy number Effective date

Prior carrier phone number Term date

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

Medicare coverage:

Prior Employee Coverage No Yes Effective date

Medicare ID Term date

Prior Spouse Coverage No Yes Effective date

Medicare ID Term date

Dental KY-80124-HD 7/2005

Group number	Benefit number	Class/Division
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Coverage type: Employee only Employee and spouse Employee and child(ren) Family Other

Plan name

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 KY-80124-HL 7/2005

Group number	Benefit number	Class/Division
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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 KY-80124-SP 7/2005

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

Class (employer will provide if needed)

Health Savings Account KY-80124-HA 7/2005

Group number	Benefit number	Class/Division
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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? \$
- 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? \$

continued on next page ↔

Group number

Social Security number

Health savings account (continued)

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 - This information will not be used to decline medical coverage KY-80124-HS 7/2005

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 2-9 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 diagnosed or received treatment for AIDS or an AIDS-related complex or other immune system disorder 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) KY-80124-WV 7/2005

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):

- | | |
|---|--|
| <input type="checkbox"/> Medical for: <input type="checkbox"/> Myself <input type="checkbox"/> My spouse <input type="checkbox"/> My dependent (child)ren
<input type="checkbox"/> Dental for: <input type="checkbox"/> Myself <input type="checkbox"/> My spouse <input type="checkbox"/> My dependent (child)ren
<input type="checkbox"/> Basic Life for: <input type="checkbox"/> Myself <input type="checkbox"/> My spouse <input type="checkbox"/> My dependent (child)ren | <input type="checkbox"/> Short-term Income Protection for: <input type="checkbox"/> Myself
<input type="checkbox"/> Health Savings Account for: <input type="checkbox"/> 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 KY-80124-AA 7/2005

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 defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.
- 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.

Bureau, Inc., employer, the Consumer Reporting Agency or banking and financial institutions having information regarding myself and my dependents, including information concerning, advice, diagnosis, treatment and care of the physical, psychiatric, 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 non-medical information 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 determine eligibility for coverage, eligibility for benefits under an existing policy, plan administration, and make claim determinations.
 - 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 we may further authorize.
 - Once personal and health (including medical, dental and pharmacy) information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal and state privacy requirements.
 - A copy of this authorization is available to me or my legal representative upon written request.
 - 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.
 - I have the right to revoke this authorization at any time:
 - To revoke this authorization, I must do so in writing and send my written revocation to Humana's Privacy Office.
 - The revocation will not apply to information that has already been released in response to this authorization.
 - The revocation will become effective after it is received by Humana's Privacy Office.

Authorization

My dependents and I authorize any physician, medical or health care practitioner, hospital, clinic, veterans administration facility, other medical or medically-related facility, third party administrator, Pharmacy Benefit Manager, insurance, HMO or reinsuring company, the Medical Information

Signature—please sign below if enrolling or waiving group coverage

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)