Employee Group Application (all group sizes)

Humana Insurance Company

CALIFORNIA

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, Life and Disability 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 ☐ New hire/Newly eligible	☐ Open Enrollment event ☐ Rehire/Reinstatement ☐ Other_____	Qualifying event date (MM/DD/YYYY) Benefit effective date (MM/DD/YYYY)

Special Enrollment			
☐ Change in family status	☐ Loss of coverage, including loss of minimum essential coverage	☐ COBRA exhaustion	☐ Termination of Medi-Cal, Healthy Families, AIM Program or CHIP
☐ Eligibility for premium assistance under Medi-Cal, Healthy Families, AIM Program or CHIP	☐ Eligibility for coverage including but not limited to: Released from incarceration; Access to new health plans as a result of a permanent move; Receiving services from a provider under another plan that is no longer participating in the plan; Misinformed you had minimum essential coverage Returning from active duty		

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		
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 / domestic partner ☐ 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 / Domestic Partner'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 / Domestic Partner ☐ 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 / Domestic Partner ☐ Employee / Individual and child(ren) ☐ Family		

BASIC LIFE /AD&D

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 /AD&D

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 / domestic partner ☐ 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:		

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 / Domestic Partner coverage
Basic Life for:	☐ Myself ☐ My spouse / domestic partner ☐ My dependent child(ren)	☐ Medicare supplement
Vision for:	☐ Myself ☐ My spouse / domestic partner ☐ My dependent child(ren)	☐ Individual coverage
Short Term Disability for:	☐ Myself	☐ Coverage under another carrier's plan provided by my employer / group
Long Term Disability for:	☐ Myself	☐ Other:_____

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 Medi-cal 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.
- If I am declining coverage for myself or my dependents (including my spouse / domestic partner) because of coverage under Medi-cal 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 may delay and/or deny life or dental 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.
- An act of fraud or an intentional misrepresentation of a material fact may void or terminate an individual's or group's coverage as specified under the terms of the Policy or Certificate. Providing incomplete, inaccurate, or untimely information may reduce an individual's or group's coverage or may increase past premium.
- To the best of my knowledge and belief, 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 complete the Group Employee Enrollment Form.
- 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.
- The falsity of any statement in the application for any life or disability policy shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.
- For your protection California law requires the following to appear on this form: **Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.**

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 collected in this application and enrollment form 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.

- This authorization shall be valid for the length of coverage under the plan in regards to a claim determination, if the claim is for an accident and sickness insurance benefit.
- The authorization for collecting information in connection with an application for life, accident and sickness or disability insurance shall be valid for 24 months from the date the authorization is signed.
- A copy of this authorization is available to me or my legal representative upon request.

Authorization for Release of Medical Records for Life or Disability

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, non-public personal health information, and any other nonmedical information), and prescription drug history to share any and all such information (excluding HIV testing and HIV status) with Humana, or its reinsurer, or its legal representatives, and its affiliates for purposes of business improvement and development.

I understand and agree:

• 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.

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.

☐ Humana Insurance Company.

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

To the best of my knowledge and belief, if I am applying for coverage for my dependents (including my spouse/domestic partner) I have gathered the necessary health information from my dependents in order to the best of my knowledge or belief complete the Group Employee Enrollment Form.

Signature: _____ Date: _____

Name and relationship of legal representative_____
(if a covered dependent)

Spouse / Domestic Partner signature: _____ Date:_____
(Only if selecting Life coverage over the guarantee issue amount.)

AGENT / PRODUCER INFORMATION

In accordance with 10 CCR § 2274.76, did you help or advise and/or answer questions regarding the application (including electronically), health questions, or health insurance for any applicant? ❍ N ❍ Y

In accordance with CIC § 10119.3, to the best of my knowledge, the information on the application is complete and accurate, and I have explained to the applicant in easy-to-understand language, the risk to the applicant of providing inaccurate infrmation and that the applicant understood the explanation.

As the Writing Agent / Producer, I acknowledge that I am responsible to meet with the primary applicant submitting the Group Employee Enrollment Form in order to fully and accurately represent the terms and conditions of the plans and services of the offering or insuring entity, or one of its subsidiaries. These provisions are available to me and the primary applicant in the benefit summary document or other plan literature.

Signed at _____ _____
County State

Writing Agent's Signature _____ Date _____

Group #: _____
SSN:_____

Humana Insurance Company

Visit us at Humana.com

Evidence of Insurability Form

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

Life and Disability plans insured or administered by Humana Insurance Company.

Please print clearly and fill in each applicable circle.

Employer / Group name	Group Number	State

Employee Information

Name	Social Security Number	Annual salary $

Street Address	APT / Suite / Box

City	State	ZIP code	Phone # ( )

Relationship	Last name, First name MI	Gender	Date of birth	Height (ft / in)	Weight (lbs)	Social Security Number
Employee / Individual		❍ F ❍ M	__/__/____	/		
Spouse / Domestic Partner		❍ F ❍ M	__/__/____	/		
Child / Dependent		❍ F ❍ M	__/__/____	/		
Child / Dependent		❍ F ❍ M	__/__/____	/		
Child / Dependent		❍ F ❍ M	__/__/____	/		
Other (specify):		❍ F ❍ M	__/__/____	/		

Coverage Options

Basic Life AD&D	**Group #:**		**Benefit #:**		**Class/Div:**	
Basic dependent life ❍ N ❍ Y						
Class (employer will provide you with this information, if needed).						
Voluntary Life AD&D	**Group #:**		**Benefit #:**		**Class/Div:**	
Voluntary employees / individual life coverage ❍ N ❍ Y		Amount (min $15,000) $				
Voluntary spouse life coverage? ❍ N ❍ Y	Amount (min $5,000) $		Voluntary child(ren) life coverage? ❍ N ❍ Y			
Short Term Disability	**Group #:**		**Benefit #:**		**Class:**	**Div:**
Short Term Disability ❍ N ❍ Y						
Class (employer will provide you with this information, if needed).						
Long Term Disability	**Group #:**		**Benefit #:**		**Class:**	**Div:**
Long Term Disability ❍ N ❍ Y						
Class (employer will provide you with this information, if needed).						

Last name:	First name:

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 6. If applying for Disability coverage, please complete questions 1 thru 10.

Yes	No	Not Sure		
❍	❍	❍	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.	In the past 5 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? **CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH INSURANCE COMPANIES AS A CONDITION OF OBTAINING HEALTH INSURANCE COVERAGE.**
			5.	In the past 5 years, has any proposed insured been diagnosed with diseases or disorders 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?
❍	❍	❍	6.	In the past 5 years, has any proposed insured sought treatment from a health care provider or specialist for any condition 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	Not Sure		
❍	❍	❍	7.	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?
❍	❍	❍	8.	Are you currently pregnant?
❍	❍	❍	9.	In the past 5 years, have you been diagnosed with or treated for psychotic, psychiatric, personality, or bi-polar disorder?

Last name:	First name:

❍	❍	❍	10.	In the past 5 years, have you been diagnosed with diseases or disorders 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, including coronary artery disease (CAD), congestive heart failure, arrhythmia; 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 __ / __ / ____

Last name:	First name:

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

Agreement

True and complete acknowledgment

I understand, agree, and represent:

- I have read this Evidence of Insurability Form or it has been read to me and answers provided are true and complete to the best of my knowledge and belief.
- 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 Evidence of Insurability Form.
- For your protection California law requires the following to appear on this form: **Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.**
- The falsity of any statement in the application for any life or disability policy shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

Authorization

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, non-public personal health information, and any other nonmedical information), and prescription drug history to share any and all such information (excluding HIV testing and HIV status) with Humana, or its reinsurer, or its legal representatives, and its affiliates for purposes of business improvement and development.

I understand and agree:

- 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.
- 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.

Employee signature	Date
Spouse signature	Date

The original version of this Evidence of Insurability Form 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.

Notice of Non-Discrimination

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate or exclude people because of their race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services. Humana Inc.:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids, or language assistance services contact **877-320-1235 (TTY: 711)**. Hours of operation: 8 a.m. – 8 p.m., Eastern time. If you believe that Humana Inc. has not provided these services or discriminated on the basis of race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services, you can file a grievance in person or by mail or email with Humana Inc.'s Non-Discrimination Coordinator at P.O. Box 14618, Lexington, KY 40512-4618, **877-320-1235 (TTY: 711)**, or **accessibility@humana.com**. If you need help filing a grievance, Humana Inc.'s Non-Discrimination Coordinator can help you.

You can also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

- U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building Washington, D.C. 20201. **800-368-1019**, **800-537-7697 (TDD)**.

California members or residents:

You may also call the California Department of Insurance toll-free hotline number: **800-927-HELP (4357)**, to file a grievance.

This notice is available at **www.humana.com/legal/non-discrimination-disclosure**.

Auxiliary aids and services, free of charge, are available to you.
877-320-1235 (TTY: 711). Hours of operation: 8 a.m. – 8 p.m., Eastern time.

Humana Inc. and its subsidiaries provide free auxiliary aids and services to people with disabilities when auxiliary aids and services are necessary to ensure an equal opportunity to participate. Services include qualified sign language interpreters, video remote interpretation, and written information in other formats.

English: Call the number above to receive free language assistance services.

Español (Spanish): Llame al número que se indica arriba para recibir servicios gratuitos de asistencia lingüística.

繁體中文 (Chinese): 您可以撥打上面的電話號碼以獲得免費的語言協助服務。

Tiếng Việt (Vietnamese): Gọi số điện thoại ở trên để nhận các dịch vụ hỗ trợ ngôn ngữ miễn phí.

한국어 **(Korean)** 무료 언어 지원 서비스를 받으려면 위 번호로 전화하십시오.

Tagalog (Tagalog – Filipino) Tawagan ang numero sa itaas para makatanggap ng mga libreng serbisyo sa tulong sa wika.

Русский (Russian): Позвоните по вышеуказанному номеру, чтобы получить бесплатную языковую поддержку.

العربية (Arabic): اتصل برقم الهاتف أعلاه للحصول على خدمات المساعدة اللغوية المجانية.

French Creole (Haitian Creole): Kreyòl Ayisyen (French Creole) Rele nimewo ki e dike anwo a pou resevwa sèvis éd gratis nan lang.

Français (French): Appelez le numéro ci-dessus pour recevoir des services gratuits d'assistance linguistique.

Polski (Polish) Aby skorzystać z bezpłatnej pomocy językowej, należy zadzwonić pod wyżej podany numer.

Português (Portuguese): Ligue para o número acima para receber serviços gratuitos de assistência no idioma.

Italiano (Italian) Chiamare il numero sopra indicato per ricevere servizi di assistenza linguistica gratuiti.

日本語 (Japanese): 無料の言語支援サービスを受けるには、上記の番号までお電話ください。

Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.

فارسی (Farsi): برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.

हिंदी (Hindi): भाषा सहायता सेवाएं मुफ्त में प्राप्त करने के लिए ऊपर के नंबर पर कॉल करें।

հայերեն (Armenian): Զանգահարեք վերը նշված հեռախոսահամարով՝ անվճար լեզվական օգնության ծառայություններ ստանալու համար:

ગુજરાતી (Gujarati): મફત ભાષા સહાય સેવાઓ મેળવવા માટે ઉપર આપેલા નંબર પર કૉલ કરો.

Hmoob (Hmong) Hu rau tus xov tooj saum toj sauv kom tau txais kev pab txhais lus dawb.

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