Humana Insurance Company

Small Group Employee and Individual Application and Enrollment Form - 1-100 Employees **CALIFORNIA**

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in the Small Group Employee and Individual Application and Enrollment Form as "Humana".

Dental, Life and Vision plans insured or administered by **Humana Insurance Company**.

Please print clearly and fill in each applicable circle. Proposed effective date: _____

Employer / Group name | Employer / Group city | State

Qualifying Event Instructions Date of Qualifying Event: _____

- ○ New business enrollment
- ○ Open Enrollment event
- ○ New hire / Newly eligible
- ○ Rehire / Reinstatement
- ○ Other_____

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

Enrollment information

Relationship	Last name, First name MI	Gender	Date of birth	Disabled? If yes, indicate reason below.	Social Security Number
Employee / Individual		○ F ○ M		○ Y ○ N	N/A (complete in Employee/ Individual Information section.)
Spouse / Domestic Partner		○ F ○ M		○ Y ○ N	
Child / Dependent		○ F ○ M		○ Y ○ N	
Child / Dependent		○ F ○ M		○ Y ○ N	
Child / Dependent		○ F ○ M		○ Y ○ N	
Other (specify):		○ F ○ M		○ Y ○ N	

Employee / Individual Information Hours worked per week: | Date of full time hire: _____

Social Security Number | Street address | APT / Suite / Box

City | State | ZIP code | Phone #

E-mail address | Occupation

Are you actively at work? ○ Y ○ N If not, reason: ○ Retiree ○ COBRA Other: | Annual salary $

Last name: First name:

Prior / Existing Coverage: **IMPORTANT - DO NOT** cancel any existing coverage until you receive written notification from Humana of your acceptance for coverage.

Dental

1. Prior dental coverage during the past 12 months (individual or other group coverage)? ○ N ○ Y

2. Prior orthodontia coverage in the past 12 months? ○ N ○ Y

Prior dental insurance carrier name	Policy #	Prior coverage type: ○ Employee / Individual only ○ Employee / Individual and spouse / domestic partner ○ Employee / Individual and child(ren) ○ Family
	Effective date	
Prior carrier phone #	Term date	

Coverage Options

Dental **Group #:** **Benefit #:** **Class/Div:**

Coverage type: ○ Employee / Individual only ○ Employee / Individual and spouse/ domestic partner ○ Employee / Individual and child(ren) ○ Family ○ No Coverage (complete waiver)

Rate Amount $ Rate Frequency (Monthly)
Rate Amount $ Rate Frequency (Monthly)
Rate Amount $_____ Rate Frequency (Monthly)
Rate Amount $_____ Rate Frequency (Monthly)

Plan name:

Basic Life AD&D **Group #:** **Benefit #:** **Class/Div:**

Basic dependent life ○ N ○ Y (If no, complete waiver.) | 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 /domestic partner life coverage? ○ N ○ Y | Amount (min $5,000) $ | Voluntary child(ren) life coverage? ○ N ○ Y

Vision **Group #:** **Benefit #:** **Class/Div:**

Coverage type: ○ Employee / Individual only ○ Employee / Individual and spouse / domestic partner ○ Employee / Individual and child(ren) ○ Family ○ No Coverage (complete waiver)

Rate Amount $ Rate Frequency (Monthly)
Rate Amount $ Rate Frequency (Monthly)
Rate Amount $ Rate Frequency (Monthly)
Rate Amount $ Rate Frequency (Monthly)

Plan name:

Beneficiary Information for Life Benefits

Primary beneficiary name (Last, First MI)	Relationship to Employee / Individual
Secondary beneficiary name (Last, First MI)	Relationship to Employee / Individual

Evidence of Health Status - Do not submit more than 90 days prior to the effective date.

COMPLETE THIS SECTION IF YOU ARE SELECTING LIFE OVER THE GUARANTEE ISSUE AMOUNT.

1.	Is anyone on this application currently taking any prescribed medication, or do you periodically take medication for a recurrent condition?	○ No ○ Yes ○ Not Sure
2a.	In the past 12 months has any applicant used any tobacco product? If yes, applies to: ○ Employee ○ Spouse/Domestic Partner ○ Other ○ Child/Dependent	○ No ○ Yes ○ Not Sure
2b.	Is any applicant currently a smoker? If yes, applies to: ○ Employee ○ Spouse/Domestic Partner ○ Other ○ Child/Dependent	○ No ○ Yes ○ Not Sure
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?	○ No ○ Yes ○ Not Sure

Last name: First name:

4. To the best of your knowledge or belief, has any person listed on this application within the past 5 years, sought treatment, received treatment, or had treatment recommended by a medical professional, been surgically treated or been hospitalized for any of the following conditions?

a.	Ablation, Anemia, Angina, Angioplasty, Arteriosclerosis, Arrhythmia, Blood Clot, Bypass, Congestive Heart Failure, Heart attack, Heart Murmur, Hemophilia, High Blood Pressure(reading higher than 140/90), High Cholesterol, High Triglycerides, ICD Implant, Irregular Heart Beat, Pacemaker, Palpitations, Sickle Cell Anemia, Stent, Tachycardia or Varicose Veins?	○ No ○ Yes ○ Not sure	h	Diabetes, Hypothyroid, Hyperthyroid, Goiter, Hashimoto Disease, Cirrhosis, Hepatitis or Fatty Liver?	○ No ○ Yes ○ Not sure
b.	Alcohol Abuse, Anorexia, Anxiety, ADD/ADHD, Autism, Drug Abuse, Cocaine Use, Marijuana Use, Opiate Use, Heroin Use, Methadone Use, Morphine Use, Bipolar, Bulimia, Depression, Manic Depression, Schizophrenia or Suicide Attempt?	○ No ○ Yes ○ Not sure	i.	Colitis, Crohn's, colostomy (○ total or ○ partial), ileostomy (○ total or ○ partial) Diverticulitis, Gallbladder, GERD, Hernia, Intestinal Polyp, Pancreatitis, Reflux, ulcer, ulcerative colitis, gastric bypass/stapling?	○ No ○ Yes ○ Not sure
c.	Stroke; Transient Ischemic Attack (TIA)?	○ No ○ Yes ○ Not sure	j.	Amputation, Breast Implants, Chronic Fatigue Syndrome, Carpal Tunnel Syndrome, Fibromyalgia, Fracture, Gout, Herniated/ Ruptured/Slipped Disc, Internal Derangement of the knee, Joint Replacement , Kyphosis, Lordosis, Muscular Dystrophy, Osteoarthritis, Rheumatoid Arthritis, Pins/Screws/Plates (○ permanent ○ temporary), Prosthetic Device, Scoliosis, Sciatica, Spina Bifida, Whiplash?	○ No ○ Yes ○ Not sure
d.	Allergy Injections, COPD, Cystic Fibrosis, Emphysema, Pneumonia, Sarcoidosis, Sleep Apnea, Asthma, Bronchitis or Tuberculosis?	○ No ○ Yes ○ Not sure	k.	ALS/Lou Gehrig's disease, Alzheimer's, Cerebral Palsy, Multiple Sclerosis, Paralysis or Parkinson's Disease, Seizure/Epilepsy?	○ No ○ Yes ○ Not sure
e.	PSA, Renal Function Tests, Chronic Renal Disease, Congenital Malformation of Kidney and Ureter, Cystic Kidney, Dialysis, End Stage Renal Disease, Glomerulonephritis, Hydronephrosis, Kidney Stones, Kidney Transplant, Nephrectomy, Nephroptosis, Nephrotic Syndrome, Polycystic Kidney Disease or Renal Abscess?	○ No ○ Yes ○ Not sure	l.	Cleft Palate/Lip, Club Foot, Developmental Delay, Mental Retardation, Down's Syndrome, anatomical defect of the heart, Skull or other physical deformities, Premature birth still receiving treatment?	○ No ○ Yes ○ Not sure
f.	Menstrual Bleeding, Pap, Breast cyst/fibroid, Endometriosis, Human Papillomavirus (HPV), Ovarian Cysts, Polycystic Ovarian Syndrome, Benign Ovarian/ Uterine Tumors or Uterine Fibroids?	○ No ○ Yes ○ Not sure	m.	Eczema, chronic ear infections, chronic sinusitis, deviated septum, glaucoma, psoriasis, Retinal Degenerative Disease, burns second degree or above?	○ No ○ Yes ○ Not sure
g.	Cancer:Basal Cell, Bladder, Blood, Bone, Breast, Brain, Cervical, Colon, Eye, Liver, Lung, Ovarian, Prostate, Stomach, Thyroid, Testicular, Lymph System, Esophageal, Leukemia, Lymphoma, Hodgkin's Disease, Melanoma, Metastasized, Squamous cell, Uterine?	○ No ○ Yes ○ Not sure	n.	Received diagnosis or treatment from a member of the medical profession for Acquired Immune Deficiency Syndrome or 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.	○ No ○ Yes ○ Not sure

5.	Has anyone on this application been advised by a member of the medical profession to have any diagnostic test, hospitalization, or surgery that has not been completed within the past 5 years?	○ No ○ Yes ○ Not Sure
6.	Within the past 5 years, has anyone on this application seen a health care provider or specialist for a routine physical/wellness exam, or been seen for any reason not previously disclosed?	○ No ○ Yes ○ Not Sure

Last name	First name

Relationship	Last name, First name MI	Height (ft / in)	Weight (lbs)
Employee			
Spouse / Domestic Partner			
Child / Dependent			
Child / Dependent			
Child / Dependent			
Other (specify):			

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 (reorder CA-51340-MH), if necessary.

Question #	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

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 is evidence of this action.

I hereby waive coverage for (check all that apply):

Dental for: ◯ Myself ◯ My spouse / domestic Partner ◯ My dependent child(ren)
Basic Life for: ◯ Myself ◯ My spouse / domestic Partner ◯ My dependent child(ren)
Vision for: ◯ Myself ◯ My spouse / domestic Partner ◯ My dependent child(ren)

I decline to apply for group coverage because of:

- ◯ Spousal /Domestic partner coverage
- ◯ Medicare supplement
- ◯ Individual coverage
- ◯ Coverage under another carrier's plan provided by my employer / group
- ◯ Other:_____

Agreement

True and complete acknowledgment

I understand, agree, and represent:

- I have read the Small Group Employee and Individual Application and 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 Small Group Employee and Individual Application and 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 Small Group Employee and Individual Application and 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 coverage and/or deny life or dental coverage with any future submissions of the Small Group Employee and Individual Application and 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 to the best of my knowledge to complete the Small Group Employee and Individual Application and Enrollment Form.

Last name: First name:

- 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 Small Group Employee and Individual Application and 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 Small Group Employee and Individual Application and Enrollment Form by Humana.

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

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 and Individual Application and 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 30 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

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 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, information relating to eligibility, prior and other insurance coverage, and personal contact information, such as name, address, phone number to share any and all such information with the company checked below, its reinsurer or its legal representatives, and its affiliates.
CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH INSURANCE COMPANIES AS A CONDITION OF OBTAINING HEALTH INSURANCE COVERAGE.

❍ Humana Insurance Company.

The Small Group Employee and Individual Application and 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 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.

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 and Individual Application and Enrollment Form.

Employee / Individual or legal representative signature: _____ Date: _____

Name and relationship of legal representative: _____

Spouse /Domestic partner signature: _____ Date:_____

Last name: First name:

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.

Will the coverage selected replace or change any existing life or disability insurance policy(s) and/or annuity(s)? ○ N ○ Y

As the Writing Agent / Producer, I acknowledge that I am responsible to meet with the primary applicant submitting the Small Group Employee and Individual Application and 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

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.