Humana Employee Enrollment Application - 2-50 Employees TEXAS

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

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. PPO, Classic, and Indemnity Medical plans and Life and Short-Term income protection plans insured or administered by Humana Insurance Company. Dental HMO benefits provided by SafeGuard Health Plans, Inc. All other Dental plans insured or administered by HumanaDental Insurance Company or Humana Insurance Company.

Please print clearly and fill in each applicable circle.

Medical Group number | Benefit number | Division

Company name | Proposed Effective Date (MMDDYYYY)

Company city | State

Employee Information

Last name | First name | MI | Date of birth

Social Security number | Phone number

Gender: ❍ Female ❍ Male | Email 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 | ❍ Retiree

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

Do you have a disability that affects your ability to communicate or read? ❍ No ❍ Yes

TX-80124-GN 1/2006

Medical

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

Plan name | Network name

HMO and POS only: (not applicable for HumanaAccess HMO or Consumer Choice POS)

Employee primary care physician | Physician ID | Current Patient: ❍ No ❍ Yes

HMO and POS only: Employee's OBGYN primary care physician (if applicable)

Physician ID | Current Patient: ❍ No ❍ Yes

Consumer Choice Medical Plans only:

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.

(Consumer Choice PPO and Consumer Choice HMO Plans are only available to groups of 2-50 employees)

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	

Group Number	Social Security Number

Medical (continued)

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/indexc.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.

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 12 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

TX-80124-MD 1/2006

Dependent Information

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 Humana Access HMO)

Primary care physician | Physician ID | Current Patient: ❍ No ❍ Yes

HMO and POS only: Employee's OBGYN primary care physician (if applicable)

Physician ID | Current Patient: ❍ No ❍ Yes

DHMO: Primary dentist | 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 Humana Access HMO)

Primary care physician | Physician ID | Current Patient: ❍ No ❍ Yes

HMO and POS only: Employee's OBGYN primary care physician (if applicable)

Physician ID | Current Patient: ❍ No ❍ Yes

DHMO: Primary dentist | Facility number | Current Patient: ❍ No ❍ Yes

Group Number | Social Security Number

Dependent Information (continued)

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 Humana Access HMO)

Primary care physician | Physician ID | Current Patient: ❍ No ❍ Yes

HMO and POS only: Employee's OBGYN primary care physician (if applicable)

Physician ID | Current Patient: ❍ No ❍ Yes

DHMO: Primary dentist | Facility number | Current Patient: ❍ No ❍ Yes

TX-80124-DP 1/2006

Dental

Group number | Benefit number | Division

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

DHMO: Primary dentist | Facility number | Current Patient: ❍ No ❍ Yes

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 and spouse ❍ Employee and child(ren) ❍ Family

TX-80124-HD 1/2006

Basic Life

Group number | Benefit number | 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

Group number | Benefit number | Division

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) $

TX-80124-HL 1/2006

Short-term Income Protection

Group number | Benefit number | Division

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

Class (employer will provide if needed)

TX-80124-SP 1/2006

Group Number	Social Security Number

Medical Health History

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

1. Within the last 24 months have you or any dependents to be covered consulted, received treatment, had medication prescribed by a doctor, psychiatrist, psychologist, or other practitioner or been diagnosed for: cancer, stroke, diabetes, heart or vascular disease, mental or emotional disorder, muscular or systemic disease (including, but not limited to arthritis or lupus), alcohol or drug use, liver, kidney, lung or intestinal disorder, infertility, transplant (recommended, pending, or completed), growth disorder, enlarged lymph nodes or other immune system disorder, or have medical claims in excess of $5,000? ❍ No ❍ Yes

2. Within the last 24 months have you or any dependents to be covered consulted, received treatment, had medication prescribed by a doctor, psychiatrist, psychologist, or other practitioner, or had positive diagnosis for: Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), enlarged lymph nodes, or other immune system disorder? ❍ No ❍ Yes

3. Are you or any dependent to be covered pregnant, or been advised in the last 12 months that hospitalization, surgery, or treatment is needed or pending? ❍ No ❍ Yes

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

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

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

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

TX-80124-MH 1/2006

Group Number	Social Security Number

Health Savings Account

Group number | Benefit number | 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.

❶	How much were you allowed to contribute to any HSA in this calendar year to date?	$
❷	How much have you contributed to any HSA in this calendar year-to-date?	$
❸	How much do you wish to contribute to the HSA for the remainder of this calendar year?	$
❹	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?	$
❺	How much have you already contributed to any HSA for the portion of your plan year that falls in the second calendar year?	$
❻	How much do you wish to contribute to your HSA for the portion of your plan year that falls in the second calendar year?	$
❼	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.

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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 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

Health savings account 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.
- 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 and Indemnity coverage hereafter, Humana reserves the right to impose a 12-month pre-existing limitation.
- 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 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, placement for adoption, or suit for adoption.

TX-80124-WV 1/2006

Group Number	Social Security Number

Agreement

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 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.

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 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, 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.
- If you decide not to sign this authorization, Humana can not complete your plan enrollment or determine your premium rate due to the inability to obtain the necessary information.
- If selecting the Health Savings Account (HSA), you authorize Humana or our banking partners to provide your account number to your employer for the purposes of depositing any contributions.
- 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, 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.

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)