Small Group Employee Enrollment Form – 1-100 Employees — COLORADO

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in the Small Group Employee Enrollment Form as "Humana". To elect primary dentist, please complete reorder CO-51340-PP.

Life plans insured or administered by Humana Insurance Company. Dental plans insured or administered by HumanaDental Insurance Company or Humana Insurance Company. Alpha Dental Plan is offered and administered by Beta Health Association, Inc. and administered by HumanaDental Insurance Company. Vision plans insured or administered by HumanaDental Insurance Company or 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 ❍ Dependent birth or adoption ❍ Loss of coverage
❍ New hire / Newly eligible ❍ Rehire / Reinstatement ❍ Marital status change ❍ Other_____

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		

** Spouse also includes partner of a civil union

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 # ( )

Language: ❍ English ❍ Spanish ❍ Other	E-mail address	Occupation

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

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:
	Effective date __/__/____	❍ Employee / Individual only ❍ Employee / Individual and spouse** ❍ Employee / Individual and child(ren) ❍ Family
Prior carrier phone # ( )	Term date __/__/____	

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Coverage Options

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

Coverage type:
❍ Employee / Individual only
❍ Employee / Individual and spouse**
❍ 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:

** Spouse also includes partner of a civil union

Last name:	First 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** life coverage? ❍ N ❍ Y		Amount (min $5,000) $			Voluntary child(ren) life coverage? ❍ N ❍ Y	

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

Coverage type:
- ❍ Employee / Individual only
- ❍ Employee / Individual and spouse**
- ❍ Employee / Individual and child(ren)
- ❍ Family
- ❍ No Coverage (complete waiver)

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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

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?	❍ N ❍ Y
2a.	In the past 12 months has any applicant used any tobacco product? If yes, applies to: ❍ Employee ❍ Spouse**/Domestic Partner ❍ Other ❍ Child/Dependent	❍ N ❍ Y
2b.	Is any applicant currently a smoker? If yes, applies to: ❍ Employee ❍ Spouse**/Domestic Partner ❍ Other ❍ Child/Dependent	❍ N ❍ Y
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?	❍ N ❍ Y
4.	Has anyone on this application been diagnosed or received treatment for an immune system disorder (i.e. Lupus, ITP), AIDS or an AIDS-related complex?	❍ N ❍ Y
5.	Within the past 5 years, has anyone on this application been diagnosed with diseases or disorders related to, counseled, consulted, or 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)?	❍ N ❍ Y
b.	Nervous, mental or emotional disorder; convulsions; epilepsy; unconsciousness; Multiple Sclerosis; Parkinson's Disease; Cerebral Palsy?	❍ N ❍ Y
c.	Stroke; Transient Ischemic Attack (TIA)?	❍ N ❍ Y
d.	Emphysema; asthma, or other disease of lungs, or respiratory organs?	❍ N ❍ Y
e.	End stage renal disease; disease of kidney?	❍ N ❍ Y
f.	Kidney stones; bladder?	❍ N ❍ Y
g.	Male or female organs; or infertility?	❍ N ❍ Y
h.	Cancer, and/or cancerous tumor; including skin cancer?	❍ N ❍ Y

i.	Diabetes; liver or thyroid disease; hepatitis; cirrhosis; or enlargement of the lymph nodes?	❍ N ❍ Y
j.	Stomach, gall bladder, digestive, intestinal, or colon disorders?	❍ N ❍ Y
k.	Rheumatoid arthritis; or back disorders; or joint disorders?	❍ N ❍ Y
l.	Paralysis, or any other physical impairment or deformity?	❍ N ❍ Y
m.	Chronic Fatigue Syndrome/Fibromyalgia?	❍ N ❍ Y
n.	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?	❍ N ❍ Y
o.	Alcoholism or drug habit?	❍ N ❍ Y

6.	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?	❍ N ❍ Y

Last name:	First name:

7.	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?	❍ N ❍ Y

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 CO-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 _ _ / _ _ / _ _ _ _

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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 / 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):	I decline to apply for group coverage because of:
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)	❍ Spousal** coverage ❍ Medicare supplement ❍ Individual coverage ❍ Coverage under another carrier's plan provided by my employer / group ❍ Other:_____

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Agreement

True and complete acknowledgment

I understand, agree, and represent:

- I have read the Small 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 Small 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 Medicaid 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 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 satisfactory to Humana.
- If I am declining coverage for myself or my dependents (including my spouse**) because of coverage under Medicaid 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**) 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.

Last name:	First name:

- Humana reserves the right to delay medical coverage and/or deny life or dental coverage with any future submissions of the Small 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**) I attest by my signature below, I have gathered the necessary health information from my dependents in order to fully and truthfully complete the Small 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.
- 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 Enrollment Form by Humana.
- It is unlawful to knowingly provide false, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

If you decide not to sign this agreement, we will decline to enroll you in an insurance product or to give you insurance benefits.

** Spouse also includes partner of a civil union

Authorization

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 the Group Employee Enrollment Form, claim or as may be otherwise lawfully required, or as I (we) may further authorize.

Authorization for Release of Medical Records for Life

If my dependents or I have selected life I authorize any third party to have information regarding myself. 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. 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.

The Small 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 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 / Individual or legal representative signature: _____ Date: _____

Name and relationship of legal representative: _____

Spouse** signature: _____ Date:_____

(Only if selecting Life coverage over the guarantee issue amount.)

** Spouse also includes partner of a civil union