Large Group 51+ Employee Application and Enrollment Form — TEXAS

You have the option to choose this Consumer Choice of Benefits Health Maintenance Organization health care plan that, either in whole or in part, does not provide state-mandated health benefits normally required in evidences of coverage in Texas. This standard health benefit plan may provide a more affordable health plan for you although, at the same time, it may provide you with fewer health plan benefits than those normally included as state-mandated health benefits in Texas. If you choose this standard health benefit plan, please consult with your insurance agent to discover which state-mandated health benefits are excluded in this evidence of coverage.

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in the Large Group Employee Application and Enrollment Form as "Humana". To elect primary care physician, dentist or OBGYN, please complete the Humana Employee Primary Care Physician/Dentist Selection section at the end of this application.

POS and Indemnity Medical plans and Life plans insured or administered by Humana Insurance Company. 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. Prepaid dental benefits offered and administered by DentiCare, Inc. (d/b/a CompBenefits). All other Dental plans insured or administered by HumanaDental Insurance Company or Humana Insurance Company. Vision plans insured and administered by HumanaDental Insurance Company or Humana Insurance Company. Short Term Disability, Long Term Disability and Workplace Voluntary Benefits plans insured or administered by Kanawha 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
❍ Dependent birth or adoption
❍ Loss of coverage
❍ Open Enrollment event
❍ Rehire/Reinstatement
❍ Marital status change
❍ Other___________________

Qualifying event date (MM/DD/YYYY) ___ / ___ / ____

Benefit effective date (MM/DD/YYYY) ___ / ___ / ____

Employee / Individual information

Last name | First name | MI

Social Security Number ___ - __ - ____ | Date of birth (MM/DD/YYYY) __ / __ / ____ | Area code (___) | Phone number ___ - ____

Street address

Apt / Suite / PO box number | Gender ❍ Female ❍ Male | Language of choice ❍ English ❍ Spanish ❍ Other

City | State | Zip code | County / Parish

E-mail address

Are you actively at work? ❍ Yes ❍ No If not, reason:
❍ Retiree ❍ COBRA/State Continuation 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

HMO/POS only — Primary care physician name | Primary care physician ID # | Current patient? ❍ Yes ❍ No

HMO/POS only — OB/GYN Primary care physician name (if applicable) | Primary care physician ID # | Current patient? ❍ Yes ❍ No

Dependent information

Enter information for each covered dependent, including spouse.

1 Dependent last name | First name | MI | Gender ❍ Female ❍ Male

Social Security Number ___ - __ - ____ | Date of birth (MM/DD/YYYY) __ / __ / ____ | Relationship ❍ Spouse ❍ Child ❍ Other:______________

Dependent status (if applicable): ❍ Disabled If disabled, indicate reason:___________________________________

Not applicable for HumanaAccess HMO

HMO/POS only — Primary care physician name | Primary care physician ID # | Current patient? ❍ Yes ❍ No

HMO/POS only — OB/GYN Primary care physician name (if applicable) | Primary care physician ID # | Current patient? ❍ Yes ❍ No

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2 Dependent last name | First name | MI | Gender ❍ Female ❍ Male

Social Security Number ___ - __ - ____ | Date of birth (MM/DD/YYYY) __ / __ / ____ | Relationship ❍ Spouse ❍ Child ❍ Other:______________

Dependent status (if applicable): ❍ Disabled If disabled, indicate reason:___________________________________

Not applicable for HumanaAccess HMO

HMO/POS only — Primary care physician name | Primary care physician ID # | Current patient? ❍ Yes ❍ No

HMO/POS only — OB/GYN Primary care physician name (if applicable) | Primary care physician ID # | Current patient? ❍ Yes ❍ No

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3 Dependent last name | First name | MI | Gender ❍ Female ❍ Male

Social Security Number ___ - __ - ____ | Date of birth (MM/DD/YYYY) __ / __ / ____ | Relationship ❍ Spouse ❍ Child ❍ Other:______________

Dependent status (if applicable): ❍ Disabled If disabled, indicate reason:___________________________________

Not applicable for HumanaAccess HMO

HMO/POS only — Primary care physician name | Primary care physician ID # | Current patient? ❍ Yes ❍ No

HMO/POS only — OB/GYN Primary care physician name (if applicable) | Primary care physician ID # | Current patient? ❍ Yes ❍ No

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4 Dependent last name | First name | MI | Gender ❍ Female ❍ Male

Social Security Number ___ - __ - ____ | Date of birth (MM/DD/YYYY) __ / __ / ____ | Relationship ❍ Spouse ❍ Child ❍ Other:______________

Dependent status (if applicable): ❍ Disabled If disabled, indicate reason:___________________________________

Not applicable for HumanaAccess HMO

HMO/POS only — Primary care physician name | Primary care physician ID # | Current patient? ❍ Yes ❍ No

HMO/POS only — OB/GYN Primary care physician name (if applicable) | Primary care physician ID # | Current patient? ❍ Yes ❍ No

Use the following alternate address for these dependents: ❍ 1 ❍ 2 ❍ 3 ❍ 4

Street address

Apt / Suite / PO box number

City | State | Zip code | County

Medical

Coverage type:
- ❍ Employee / / Individual only
- ❍ Employee / / Individual & spouse
- ❍ Employee / / Individual & child(ren)
- ❍ Family
- ❍ Other

Office use only
Group # | Benefit # | Class/Div #

Plan name | Network name

Do you or any covered dependent(s) currently have other medical coverage, such as a spouse's plan, another Humana medical plan, or Medicare? ❍ Yes ❍ No If yes, list all: (This section must be completed for Humana to process any medical claims.)

Medicare ID or medical carrier name:

Starting date (MM/DD/YYYY) / /

End date, if applicable (MM/DD/YYYY) / /

Coverage Type (check all that apply)
- ❍ Employee / Individual
- ❍ Spouse
- ❍ Child(ren)

Medicare ID or medical carrier name:

Starting date (MM/DD/YYYY) / /

End date, if applicable (MM/DD/YYYY) / /

Coverage Type (check all that apply)
- ❍ Employee / Individual
- ❍ Spouse
- ❍ Child(ren)

Have you or any covered dependent(s) had medical insurance from a company (including another Humana plan) in the past 18 months? ❍ Yes ❍ No If yes, list all: (This section must be completed for Humana to process any medical claims.)

Prior medical carrier name:

Starting date (MM/DD/YYYY) / /

End date, if applicable (MM/DD/YYYY) / /

Coverage Type (check all that apply)
- ❍ Employee / Individual
- ❍ Spouse
- ❍ Child(ren)

Prior medical carrier name:

Starting date (MM/DD/YYYY) / /

End date, if applicable (MM/DD/YYYY) / /

Coverage Type (check all that apply)
- ❍ Employee / Individual
- ❍ Spouse
- ❍ Child(ren)

Medical Health History (for 51-100 groups) – Do not submit more than 90 days prior to the effective date

1. Within the past 24 months have you or any dependent to be covered had or been treated for an illness or injury, had surgery or hospitalization recommended, or are currently pregnant? ❍ N ❍ Y
2. Within the past 24 months have you or any dependent to be covered been prescribed medication? ❍ N ❍ Y
3. Have you or any dependent to be covered incurred medical expenses in excess of $7,500 in the past 12 months? ❍ N ❍ Y

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 TX-51340-MH), if necessary.

Question#

Person Treated Last name

First Name

Condition

Treatments received

Medications

Current or future treatments or medications

Date diagnosed (MM/DD/YYYY)

/ /

Date last seen by a doctor (MM/DD/YYYY)

/ /

Health Savings Account (HSA) Applicable only with High Deductible Health Plan selection

Do you elect the Health Savings Account?
❍ Yes ❍ No If no, complete waiver section

If you have medical coverage under another plan, you may not be eligible for an HSA. Please check with your tax advisor for details.

Office use only
Group # Benefit # Class/Div #

Please refer to Humana's HSA contribution worksheet to calculate your maximum allowed contribution. You can find additional information on HSAs on Humana.com. Select the Quick Link for Spending Account information on the member page.

Beneficiary for this account will be the employee / individual 's estate. You may change beneficiary information on file with the bank that administers the HSA once the account is established.

Flexible Spending Account (FSA)

Do you elect the flexible health account?
❍ Yes ❍ No If no, complete waiver section

Annual amount elected:

$, .00

Office use only
Group # Benefit # Class/Div #
FSA HC

Start date (MM/DD/YYYY)

/ /

End date (MM/DD/YYYY)

/ /

Do you elect the flexible dependent health account? ❍ Yes ❍ No If no, complete waiver section

Annual amount elected:

$, .00

Office use only
Group # Benefit # Class/Div #
FSA DC

Start date (MM/DD/YYYY)

/ /

End date (MM/DD/YYYY)

/ /

Dental

Coverage type:
❍ Employee / Individual only
❍ Employee / Individual & spouse
❍ 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'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 ❍ 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
❍ 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):
$, .00

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 life coverage? ❍ Yes ❍ No If no, complete waiver section

If yes, voluntary souse life coverage (minimum of $5,000): $, .00

Do you elect voluntary child(ren) life coverage? ❍ Yes ❍ No If no, complete waiver section

Vision

Coverage type:
❍ Employee / Individual only
❍ Employee / Individual & spouse
❍ 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
Buy-up percent/amount__________

Office use only
Group # Benefit # Class # Div #

Long Term Disability

Do you elect long term disability coverage?
❍ Yes ❍ No If no, complete waiver section
Buy-up percent/amount__________

Office use only
Group # | Benefit # | Class # | Div #

Group Term Life / AD&D

Office use only Group # Benefit # Class # Div #

	Coverage requested for (check all that apply)	Coverage requested (complete only if plan provides a choice of benefit schedules)	Cost per pay period
Employee / Individual	❍ Basic Term Life		$, .00
	❍ Supplemental Term Life*		$, .00
	❍ Basic AD&D		$, .00
	❍ Supplemental AD&D		$, .00
Spouse	❍ Basic Term Life		$, .00
	❍ Supplemental Term Life*		$, .00
	❍ Basic AD&D		$, .00
	❍ Supplemental AD&D		$, .00
Child(ren)	❍ Basic Term Life		$, .00
	❍ Supplemental Term Life*		$, .00
	❍ Basic AD&D		$, .00
	❍ Supplemental AD&D		$, .00

*Complete Evidence of Insurability form if selecting one of these benefit amounts.

Workplace Voluntary Benefits: Optional riders availability based on employer / group election.

Accident - 2012

Office use only Group # Benefit # Class # Div #

❍ Accident ❍ N ❍ Y Benefit Level: ❍ 1 ❍ 2 ❍ 3 ❍ 4

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

Disability Income Plus

Office use only Group # Benefit # Class # Div #

❍ Disability Income Covering Accident and Sickness ❍ N ❍ Y
Base Benefit Period: ❍ 3 Month ❍ 6 Month ❍ 1 Year ❍ 2 Year ❍ 3 Year
Base Elimination Period: ❍ 0/7 ❍ 7/7 ❍ 0/14 ❍ 14/14 ❍ 30/30 ❍ 60/60 ❍ 90/90 ❍ 180/180 ❍ 365/365

❍ Disability Income Covering Accident and Sickness with Waiver of Elimination Period ❍ N ❍ Y Monthly benefit $, .00
Base Benefit Period: ❍ 3 Month ❍ 6 Month ❍ 1 Year ❍ 2 Year ❍ 3 Year
Base Elimination Period: ❍ 0/7 ❍ 7/7 ❍ 0/14 ❍ 14/14
Optional Disability Income Benefits: ❍ ICU/CCU Benefit ❍ $200 ❍ $400 ❍ $600 ❍ $800
❍ Physical Therapy Benefit
❍ COBRA Rider COBRA monthly benefit $, .00

Level Term Life

Office use only Group # Benefit # Class # Div #

❍ Level Term Life ❍ N ❍ Y Coverage type: ❍ Employee / Individual only ❍ Spouse ❍ Child(ren) ❍ No Coverage
Base Plan: ❍ 10 Year Term ❍ 20 Year Term
Optional Benefit: ❍ Automatic Benefit Increase

Employee / Individual Benefit $, .00 Spouse Benefit $, .00 Child(ren) Benefit $, .00

If your employer or group has elected the critical illness rider, does anyone on this application have a parent, brother, or sister with a history of heart attack, heart disease, stroke, or cancer diagnosis prior to age 60? ❍ N ❍ Y
If yes, please indicate whether this applies to you (employee / individual), your spouse or a dependent.
❍ You (employee / individual) ❍ Spouse ❍ Dependent Name____

Critical Illness

Office use only Group # Benefit # Class # Div #

❍ Critical Illness ❍ N ❍ Y Coverage type: ❍ Employee / Individual only ❍ Employee / Individual and spouse
❍ Critical Illness and Cancer ❍ N ❍ Y ❍ Employee / Individual and child(ren) ❍ Family

Optional Benefits: ❍ Automatic Benefit Increase ❍ Health Screening ❍ Return on Premium Employee / Individual Benefit $, .00

Does anyone on this application have a parent, brother, or sister with a history of heart attack, heart disease, stroke, or cancer diagnosis prior to age 60? ❍ N ❍ Y If yes, please indicate whether this applies to you (employee / individual), your spouse or a dependent.
❍ You (employee / individual) ❍ Spouse ❍ Dependent Name____

Group Lump Sum Cancer

Office use only Group # Benefit # Class # Div #

❍ Group Lump Sum Cancer ❍ N ❍ Y Coverage type: ❍ Employee / Individual only ❍ Employee / Individual and spouse
❍ Employee / Individual and child(ren) ❍ Family

Does anyone on this application have a parent, brother, or sister with a history of cancer diagnosis prior to age 60?
❍ N ❍ Y If yes, please indicate whether this applies to you (employee / individual), your spouse or a dependent.
❍ You (employee / individual) ❍ Spouse ❍ Dependent Name____

Rider: ❍ Automatic Benefit Increase ❍ Health Screenings Benefit $, .00

Hospital Indemnity

Office use only Group # Benefit # Class # Div #

❍ Hospital Indemnity ❍ N ❍ Y Coverage type: ❍ Employee / Individual only ❍ Employee / Individual and spouse
❍ Employee / Individual and child(ren) ❍ Family

Plan type: ❍ 1 ❍ 2 ❍ 3 ❍ 4

If your employer or group has elected the critical illness rider, does anyone on this application have a parent, brother, or sister with a history of heart attack, heart disease, stroke, or cancer diagnosis prior to age 60? ❍ N ❍ Y
If yes, please indicate whether this applies to you (employee / individual), your spouse or a dependent.
❍ You (employee / individual) ❍ Spouse ❍ Dependent Name____

Beneficiary Information for Life, Disability and Workplace Voluntary Benefits

Primary beneficiary
Last name First name MI

Relationship to employee / individual

Secondary beneficiary
Last name First name 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 workplace voluntary (excludes Accident) benefits and/or 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: ❍ You (employee) ❍ Dependent 1 ____ ❍ Dependent 2 ____ ❍ Dependent 3 ____ ❍ Dependent 4 ____	❍ N ❍ Y
2b.	Is any applicant currently a smoker? If yes, applies to: ❍ You (employee) ❍ Dependent 1 ____ ❍ Dependent 2 ____ ❍ Dependent 3 ____ ❍ Dependent 4 ____	❍ 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 had a positive diagnosis or received treatment by a medical practitioner 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

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
8.	Is anyone on this application currently pregnant? If yes, please indicate anticipated delivery date below. Anticipated delivery date:_______________	❍ N ❍ Y
9.	**Hospital Indemnity only:** Can you perform your activities of daily living (ADL's) without need of assistance? ADL's include: Bathing, Transferring, Feeding, Dressing and Bowl/Bladder/Toileting	❍ N ❍ Y

❍ Employee last name | First Name | MI | Height (ft/in) | Weight (lbs)

❍ Dependent 1 last name | First Name | MI | Height (ft/in) | Weight (lbs)

❍ Dependent 2 last name | First Name | MI | Height (ft/in) | Weight (lbs)

❍ Dependent 3 last name | First Name | MI | Height (ft/in) | Weight (lbs)

❍ Dependent 4 last name | First Name | MI | Height (ft/in) | Weight (lbs)

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 TX-51340-MH), if necessary.

Question# | Person Treated Last name | First Name

Condition | Treatments received

Medications | Current or future treatments or medications

Date diagnosed (MM/DD/YYYY) ___ / ___ / ______ | Date last seen by a doctor (MM/DD/YYYY) ___ / ___ / ______

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):

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)
Vision for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Short Term Disability for:	❍ Myself		
Long Term Disability for:	❍ Myself		
Health Savings Account for:	❍ Myself		
Waive Coverage for Workplace Voluntary Benefits:			
Level Term Life for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Critical Illness for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Group Lump Sum Cancer for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Accident for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Hospital Indemnity for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Disability Income Plus for:	❍ Myself		

I decline to apply for group coverage because of:

- ❍ Spousal coverage
- ❍ Medicare supplement
- ❍ Individual coverage
- ❍ Coverage under another carrier's plan provided by my employer / group
- ❍ Other:_________________________

True and complete acknowledgement

I understand, agree, and represent:

- I have read the Large Group Employee 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 Large Group Employee 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 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 Large Group Employee 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 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 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.
- If any deductions are required for this coverage, I authorize those deductions from my earnings. If selecting the Health Savings Account (HSA), I authorize Humana or its banking partners to provide my account number to my employer / group for the purposes of depositing any contributions.
- 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 Large Group Employee Application and Enrollment Form.
- If I have selected workplace voluntary benefits, and if coverage is not issued as initially applied for, I hereby authorize Humana to decrease or increase the premium or rate amount stated on the Large Group Employee Application and Enrollment Form to cover the benefit actually issued.
- 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 Large Group Employee Application and Enrollment Form by Humana.
- Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of fraud.

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 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 Large Group Employee Application and 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 or Disability

If my dependents or I have selected life or disability, 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 Large Group Employee 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 any group coverage

Employee / Individual or legal representative signature | Date __ / __ / ____

Name and relationship of legal representative (if a covered dependent) ______________________________

Required Disclosure Notice for POS & HMO Consumer Choice Benefit Plans

Below is the Required Disclosure Notice for Group POS & 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.

If your employer has selected the Consumer Choice POS 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 POS State Mandates	**Excluded HMO State Mandates**
Invitro	Invitro
Hearing Aid	Hearing Aid

The Consumer Choice Health Benefit Plan may include requirements and/or restrictions on deductibles, coinsurance, copayments, or maximum benefit amounts that differ from other POS & 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.texas.gov/consumer/index.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.

Agent / Producer Information

If applying for workplace voluntary benefits, this section to be completed by Agent or Producer.

1. Agent / Agency of Record:	**2. Agent / Agency of Record:**
Name (print)	Name (print)
Humana Agent #	Humana Agent #
Commission split:	Commission split:
1. Writing Agent / Producer:	**2. Writing Agent / Producer:**
Name (print)	Name (print)
Humana Agent #	Humana Agent #
Commission split:	Commission split:

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 Large Group Employee 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 including an explanation of the Consumer Choice Benefit Plans. 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.

Humana Employee Primary Care Physician/Dentist Selection (for HMO/DHMO use only)

In addition to a primary care physician, you may select an OB/GYN to provide obstetrical or gynecological services. You are not required to select an OB/GYN, but may instead receive obstetrical or gynecological services from your primary care physician.

Please print clearly and fill in each applicable circle.

Primary Care Physician Selection (for HMO use only)

	Member Last name First name MI	Primary care physician name	Physician ID	Current patient
Employee				❍ N ❍ Y
Spouse				❍ N ❍ Y
Child				❍ N ❍ Y
Child				❍ N ❍ Y
Child				❍ N ❍ Y
Other (specify)				❍ N ❍ Y

Primary Dentist Selection (for DHMO use only)

	Member Last name First name MI	Primary dentist name	Dentist ID	Current patient
Employee				❍ N ❍ Y
Spouse				❍ N ❍ Y
Child				❍ N ❍ Y
Child				❍ N ❍ Y
Child				❍ N ❍ Y
Other (specify)				❍ N ❍ Y

OBGYN Primary Care Physician Selection (for HMO use only)

Relationship	Member Last name, First name MI	Primary care OBGYN physician name	Physician ID	Current patient?
Employee				❍ N ❍ Y
Spouse				❍ N ❍ Y
Child				❍ N ❍ Y
Child				❍ N ❍ Y
Child				❍ N ❍ Y
Other (specify):				❍ N ❍ Y