Large Group Employee and Individual Application and Enrollment Form

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

Medical and Life plans insured or administered by Humana Insurance Company. HMO plans offered or administered by Humana Health Plan, Inc. and insured or administered by Humana Insurance Company. Dental plans insured or administered by HumanaDental Insurance Company or Humana Insurance Company. Alpha Dental Plan insured and administered by Beta Health Association, Inc. Vision plans insured or administered by CompBenefits Insurance Company or HumanaDental Insurance Company or Humana Insurance Company. Short Term Disability, Long Term Disability, Life and Workplace Voluntary plans insured by Kanawha Insurance Company.

Print clearly and completely fill in each applicable circle.

Employer / Group name: INNOVAR GROUP

Employer / Group city: GREENWOOD VILLAGE

State: CO

Qualifying Event Instructions — **Office use only**

- ○ New business enrollment
- ○ Open Enrollment event
- ○ Marital status change
- ○ Other_____
- ○ New hire/Newly eligible
- ○ Rehire/Reinstatement
- Qualifying event date (MM/DD/YYYY) / /
- Benefit effective date (MM/DD/YYYY) / /
- ○ Dependent birth or adoption
- ○ Loss of coverage

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

City | State | Zip code | County / Parish

E-mail address

Employment status ○ Full-time employee / individual ○ Retiree ○ COBRA 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:_____

Hours Worked per Week

☐ BASE PLAN

☐ BUY-UP PLAN

Last name: First name:

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): ❍ Full-time student ❍ 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 — OBGYN Primary care physician name (if applicable) | Primary care physician ID # | Current patient? ❍ Yes ❍ No

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): ❍ Full-time student ❍ 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 — OBGYN Primary care physician name (if applicable) | Primary care physician ID # | Current patient? ❍ Yes ❍ No

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): ❍ Full-time student ❍ 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 — OBGYN Primary care physician name (if applicable) | Primary care physician ID # | Current patient? ❍ Yes ❍ No

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): ❍ Full-time student ❍ Disabled
If disabled, indicate reason:_____

Last name: First name:

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)
- ❍ My spouse* ❍ My dependent child(ren)
- ❍ My spouse* ❍ My dependent child(ren)
- ❍ My spouse* ❍ My dependent child(ren)

I decline to apply for group coverage because of:

- ❍ Spousal/ Partner to a civil union coverage
- ❍ Medicare supplement
- ❍ Individual coverage
- ❍ Coverage under another carrier's plan provided by my employer / group
- ❍ Other: _____

Last name: | First name:

True and complete acknowledgement

I understand, agree, and represent:

- I have read the Large 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 Large 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 of insurance.
- 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. I understand eligibility for enrollment does not apply to a High Deductible Health Plan (HDHP).
- In the event that I should decide to apply for coverage hereafter, that subsequent Large 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 satisfactory to Humana.
- 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 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. I understand eligibility for enrollment does not apply to an HDHP.
- Humana reserves the right to delay medical coverage and/or deny life or dental coverage with any future application for coverage.
- 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 and Individual 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 and Individual 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 void, reduce, or increase past premium, or terminate an individual's coverage or the group's coverage.
- 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 and Individual Application and Enrollment Form by Humana.
- Any person who willingly and knowingly submits this Large Group Employee and Individual Application and Enrollment Form containing a false, incomplete, or deceptive statement may be guilty of insurance 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 this Large Group Employee and Individual 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 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 any group coverage

Employee / Individual or legal representative signature

Date ___ / ___ / _____

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