Group Employee and Individual Application and Enrollment Form - 1-100 Employees — Florida

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 "Humana". To elect primary care physician or dentist, please complete reorder FL-51340-PP.

PPO, EPO and Indemnity plans insured by Humana Health Insurance Company of Florida, Inc. POS and HMO plans offered by Humana Medical Plan, Inc. Humana National POS plan offered by Humana Medical Plan, Inc. Life plans insured or administered by Humana Insurance Company. Prepaid, Basic, Intermediate and High Dental plans underwritten by The Dental Concern, Inc. Prepaid and AdvantagePlus Dental plans offered and administered by CompBenefits Company. All other Dental plans insured or administered by HumanaDental Insurance Company or Humana Insurance Company. Vision plans insured or administered by Humana Insurance Company or CompBenefits Insurance Company or CompBenefits Company. Short Term Disability, Long Term Disability, Life and Workplace Voluntary plans insured or administered by Kanawha 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		

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
Employment status (check one) ○ Active ○ Retiree ○ COBRA			Annual salary $

Coverage Options

Vision Group # Benefit #: Class/Div:

Coverage type:

○ Employee / Individual only	Rate Amount $_____	Rate Frequency (Monthly)
○ Employee / Individual and spouse	Rate Amount $_____	Rate Frequency (Monthly)
○ Employee / Individual and child(ren)	Rate Amount $_____	Rate Frequency (Monthly)
○ Family	Rate Amount $_____	Rate Frequency (Monthly)
○ No Coverage (complete waiver)		

Plan name:

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 is evidence of this action.

I hereby waive coverage for (check all that apply):	I decline to apply for group coverage because of
Vision for: ○ Myself ○ My spouse ○ My dependent child(ren)	○ Spouse coverage ○ Medicare supplement ○ Individual coverage ○ Coverage under another carrier's plan provided by my employer / group ○ Other:_____

Agreement

True and complete acknowledgement

I understand, agree and represent:

- I have read the 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 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 becomes 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).
- I have read the 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 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 becomes 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).
- Has anyone on this application been advised by a licensed medical provider to have any diagnostic test, hospitalization, or surgery that has not been completed within the past 5 years?
- 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. I understand eligibility for enrollment does not apply to a High Deductible Health Plan (HDHP).
- 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 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 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 Group Employee and Individual Application and Enrollment Form by Humana.

Last name:	First name:

- Any person who willingly and knowingly submits the 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 u□sed 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.

The 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.

Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree

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.)

Agent / Producer Information

If applying for workplace voluntary products, 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 #
Florida License ID #	Florida License ID #
Commission split:	Commission split:
1. Writing Agent / Producer:	**2. Writing Agent / Producer:**
Name (print)	Name (print)
Humana Agent #	Humana Agent #
Florida License ID #	Florida License ID #
Commission split:	Commission split:

Agent replacement question:

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 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.