HUMANA.

ILLINOIS EMPLOYEE APPLICATION /ENROLLMENT/CHANGE FORM

Group Number

HMO plans offered by Humana Health Plan, Inc.
PPO and Classic & Indemnity medical plans & Life and STD plans insured by HUMANA INSURANCE COMPANY formerly Employers Health Insurance Company
Dental PPO and Traditional Preferred plans insured by HumanaDental Insurance Company or HUMANA INSURANCE COMPANY formerly Employers Health Insurance Company
Dental Prepaid plans underwritten by The Dental Concern, Ltd.
Please print using black ink. Attach additional sheets if necessary; sign and date all attachments.

1 Employer Data - Complete with the name and location of the employer company offering benefits.

NAME OF EMPLOYER | CITY | STATE | ZIP CODE

2 Employee Information - Welcome! Please indicate if you are a: ☐ New Applicant or ☐ Current Insured/Plan Subscriber

EMPLOYEE/LAST NAME | FIRST NAME | M.I. | SEX | SSN | BIRTH DATE

EMPLOYEE STREET ADDRESS | HOME PHONE ( ) | E-MAIL ADDRESS HOME / WORK

CITY | STATE | ZIP | HEIGHT FT IN | WEIGHT LBS

EMPLOYEE'S OCCUPATION | DATE OF FULL-TIME EMPLOYMENT/REHIRE | ANNUAL SALARY $ ☐ HOURLY ☐ SALARY

PRIMARY CARE PHYSICIAN NAME* | CURRENT PATIENT? Y/N | MEDICAL NETWORK* | VENDOR ID #*

DENTIST NAME* | CURRENT PATIENT? Y/N | DENTIST NETWORK* | FACILITY #*

The following applicants must complete height and weight information: members of groups with 2-9 applicants for medical coverage to include dependents over age 15, applicants requesting Life insurance over the guaranteed issue amount, and all late enrollees applying for Short Term Disability or Life coverage. * Complete this section if enrolling in a plan that requires the selection of a Primary Care Physician/Dentist. Refer to your Provider Directory.

3 Dependent Information - Please list any dependents to be covered.

NAME/RELATIONSHIP (WRITE LAST NAME IF DIFFERENT FROM EMPLOYEE)	BIRTH DATE	SEX	HGHT	WGHT	PRIMARY CARE PHYSICIAN NAME*	VENDOR ID #*	CURRENT PATIENT?	DENTIST NAME	CURRENT PATIENT?
SPOUSE		F/M	FT IN	LBS			Y/N		Y/N
CHILD ☐ CHECK IF FULL-TIME STUDENT		F/M	FT IN	LBS			Y/N		Y/N
CHILD ☐ CHECK IF FULL-TIME STUDENT		F/M	FT IN	LBS			Y/N		Y/N
CHILD ☐ CHECK IF FULL-TIME STUDENT		F/M	FT IN	LBS			Y/N		Y/N
CHILD ☐ CHECK IF FULL-TIME STUDENT		F/M	FT IN	LBS			Y/N		Y/N

4 Plan Selections

Medical Coverage: ☐ **Employee** ☐ **Employee & Child(ren)** ☐ **Employee & Spouse** ☐ **Family**
Dental Coverage: ☐ **Employee** ☐ **Employee & Child(ren)** ☐ **Employee & Spouse** ☐ **Family**

If you have been given a choice of plans (e.g., HMO, PPO, Voluntary, etc.) please indicate:
Medical Plan/Option_____ **Dental Plan**_____
If you have been given a choice of Medical Networks, please indicate Network Selection:_____
Short Term Disability Coverage ☐ YES ☐ NO (Amount/Class if Applicable)_____
Basic Life/AD&D (Amount/Class if Applicable)_____
If this coverage is offered by your employer, you will automatically be enrolled upon receipt of this *completed* form unless in a contributory group you waive this coverage.
Primary Beneficiary name(s)_____
Secondary Beneficiary name(s)_____
Basic Dependent Life: If offered by your employer, and you have enrolled for dependent coverage, your dependents will automatically be enrolled, unless in a contributory group you waive this coverage.
Voluntary Employee Life/AD&D ☐ YES ☐ NO Amount_____
Primary Beneficiary name(s)_____
Secondary Beneficiary name(s)_____
Voluntary Dependent Spouse Life/AD&D ☐ YES ☐ NO Amount_____ (Available only if Voluntary Employee Life AD&D is selected)
Voluntary Dependent Child(ren) Life ☐ YES ☐ NO

Employee Name_____Social Security #_____Group #_____

5 Enrollment Questions

1. How many hours per week do you work for this employer?_____hrs/wk
2. Are you or any dependent now disabled or unable to perform normal activities? ☐ NO ☐ YES
   Name_____Since what date?_____
   Reason_____
3. Are you or any of your dependents eligible for Medicare benefits? ☐ NO ☐ YES
   Name_____Since what date?_____
   Reason_____
4. Within the past 18 months, have you or your dependent(s) had any individual or other group MEDICAL coverage?
   ☐ NO ☐ YES Medical Carrier Name:_____Policy Number:_____
   Address:_____Phone Number:_____
   Effective date:_____Term date:_____Still in effect? ☐NO ☐ YES
   Who was/is covered on the policy listed above:_____
5. Within the past 12 months, have you or your dependent(s) had any individual or other group DENTAL coverage?
   ☐ NO ☐ YES Orthodontia coverage? ☐ NO ☐ YES
   Dental Carrier Name:_____Policy Number:_____
   Address:_____Phone Number:_____
   Effective date:_____Term date:_____Still in effect? ☐NO ☐YES
   Who was/is covered on the policy listed above:_____

6 Health Status - Please provide details to any "Yes" answers in the space provided below.

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, lupus), alcohol or drug use, liver, kidney, lung or intestinal disorder, infertility, transplant (recommended, pending or completed), growth 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 been diagnosed 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

Attach additional signed & dated sheets if necessary.

Person Treated:
Condition:
Treatment Dates (past and future):
Medication:
Last time seen by a doctor for this condition:
Person Treated:
Condition:
Treatment Dates (past and future):
Medication:
Last time seen by a doctor for this condition:

Employee Name_____Social Security #_____Group #_____

7 Waiver - Refusal of Coverage

You *must* complete the section below only if you are waiving (declining) any of the coverage available to you through your employer. Please note, Employee can only waive Basic Life/AD&D and Short-Term Disability if plan is contributory.

This is to acknowledge that I have been given opportunity to apply for group coverage available to me and my dependents pursuant to state law through the above named employer. I hereby waive insurance coverage for:

Myself: . . . . . ☐Medical ☐ Dental ☐ Voluntary Life/AD&D ☐ Basic Life/AD&D ☐ Short Term Disability

My Spouse: . . . . . ☐Medical ☐ Dental ☐ Voluntary Life/AD&D ☐ Basic Dependent Life

Dependent Children: ☐Medical ☐ Dental ☐ Voluntary Life ☐ Basic Dependent Life

I ***decline*** **to apply for group coverage because of:** ☐ Spousal coverage ☐ Medicare supplement ☐ Individual health coverage ☐ Coverage under another carrier's plan provided by the employer named above ☐ Other_____

I proclaim that I was not pressured or forced by the employer named above, the writing agent, or Humana Insurance Company, HumanaDental Insurance Company or Humana into waiving (declining) the above noted coverage. I understand that 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) which may require additional limitations and waiting periods. I also understand that I may be required to furnish, at my own expense, evidence of health status satisfactory to Humana Insurance Company, HumanaDental Insurance Company or Humana. I understand that Humana Insurance Company, HumanaDental Insurance Company and Humana reserves the right to deny coverage with any future application for coverage. I freely and voluntarily waive the above noted coverage.

If you are declining medical enrollment for yourself or your dependents (including your spouse) because of other medical coverage, you may in the future be able to enroll yourself or your dependents in the medical plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

Date_____**Employee Signature X**_____

8 Agreement

I hereby acknowledge that I have read the above statements or that they have been read to me. I declare and agree that the answers are, to the best of my knowledge and belief, complete and true and, together with any supplements thereto, shall be the basis for any certificate of coverage/certificate of insurance issued. I understand and agree that neither the employer nor the agent has the authority to waive a complete answer to any question, pass on insurability, alter any contract, or waive any of the company's other rights or requirements. **I hereby agree that no insurance will be effective until the date specified by the company on the certificate of coverage/certificate of insurance after this application has been accepted.** I understand that any misrepresentation contained herein relied on by the Company may be used to reduce or deny a claim or void the contract within the contestable period if such misrepresentation materially affects the acceptance of the risk.

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. An Enrollment Form should not be submitted more than 60 days prior to the effective date. This document will become a part of the certificate if coverage is approved.

Date_____**Employee Signature X**_____

Employee Name_____Social Security #_____Group #_____

9 Evidence of Health Status - Please provide details to any "Yes" answers in the space provided below.

Complete this section for employee and dependents enrolling who are members of groups with 2-9 applicants for medical coverage and applicants requesting Life insurance over the guarantee issue amount, and all late enrollees applying for Short Term Disability or Life coverage.

	Yes	No
1. Are you or any dependent currently under any treatment or prescribed medications?	☐	☐
2. Have you or any dependent had unexplained weight loss or fatigue in the past 12 months?	☐	☐
3. Have you or any dependent ever had, been diagnosed with, counseled, consulted, or treated for any of the following:		
A. Chest pain; disease of heart, arteries or blood vessels; high or low blood pressure?	☐	☐
B. Nervous, mental or emotional disorder; convulsions; epilepsy; unconsciousness?	☐	☐
C. Asthma or other disease of lungs or respiratory organs?	☐	☐
D. Kidney stones; disease of the kidney, bladder, male or female organs; or infertility?	☐	☐
E. Cancer, and/or cancerous tumor? (state type; part of body)	☐	☐
F. Diabetes; liver or thyroid disease; or enlargement of the lymph nodes?	☐	☐
G. Stomach, gall bladder, intestinal or colon disorders?	☐	☐
H. Rheumatoid arthritis or back disorders?	☐	☐
I. Phlebitis, paralysis, or any other physical impairment or deformity?	☐	☐
J. Alcoholism or drug habit, or been a member of Alcoholics Anonymous?	☐	☐
4. Have you or any dependent been diagnosed or received treatment for AIDS or an AIDS-related complex or other immune system disorder within the past 5 years?	☐	☐
5. Have you or any dependent been hospitalized or had hospitalization advised, had surgery or been advised to have surgery, had any injury, illness, medical attention or medical advice or treatment during the past 5 years for any reason not already mentioned?	☐	☐
6. Are you or any dependent pregnant or ever had a cesarean section?	☐	☐

Please give details to "yes" answers from questions above (specify question number). Attach additional signed & dated sheets if necessary.

No.	Person Treated	Illness or Impairment & Medication (if any)	Dates Treated	Name/Address of Physician and/or Hospital

Agreement

I hereby acknowledge that I have read the above statements or that they have been read to me. I declare and agree that the answers are, to the best of my knowledge and belief, complete and true and, together with any supplements thereto, shall be the basis for any certificate of coverage/certificate of insurance issued. I understand and agree that neither the employer nor the agent has the authority to waive a complete answer to any question, pass on insurability, alter any contract, or waive any of the company's other rights or requirements. **I hereby agree that no insurance will be effective until the date specified by the company on the certificate of coverage/certificate of insurance after this application has been accepted.** I understand that any misrepresentation contained herein relied on by the Company may be used to reduce or deny a claim or void the contract within the contestable period if such misrepresentation materially affects the acceptance of the risk.

Authorization: I authorize any physician, medical practitioner, hospital, clinic, veterans administration facility, other medical or medically-related facility, insurance, HMO or reinsuring company, the Medical Information Bureau, Inc., or Consumer Reporting Agency having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or my covered dependents, and any other non-medical information of me or my covered dependents to give to Humana Insurance Company or Humana or their legal representative any and all such information.

I understand the information obtained by use of the authorization may be used by Humana Insurance Company or Humana to determine eligibility for coverage and eligibility for benefits under an existing policy. Any information obtained will not be released by the insurer or health maintenance organization to any person or organization except to reinsuring companies, the Medical Information Bureau, Inc. or other persons or organizations performing business or legal services in connection with any application, claim or as may be otherwise lawfully required, or as I may further authorize. I know that I may request to receive a copy of this authorization. I agree that a photographic copy of this authorization shall be as valid as the original. I agree that this authorization shall be valid for two years from the date shown below.

Date_____Employee Signature X_____

Date_____Spouse's Signature X_____(if dependent coverage)