

**Group Employee Application and Enrollment Form - 2-50 Employees**

**Texas**

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in the Small 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.

PPO and Classic Medical 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 and AdvantagePlus 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 plan insured and administered by Humana Insurance Company. Short Term Disability, Long Term Disability, and Workplace Voluntary Benefits plans insured or administered by Kanawha Insurance Company. Life plans insured or administered by Humana Insurance Company or Kanawha Insurance Company.

Please print clearly and fill in each applicable circle.

Proposed effective date: \_\_/\_\_/\_\_\_\_

Employer / Group name	Employer / Group city	State
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**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		<input type="radio"/> F <input type="radio"/> M	__/__/____	<input type="radio"/> Y <input type="radio"/> N	N/A (complete in Employee/ Individual Information section.)
Spouse / Domestic Partner		<input type="radio"/> F <input type="radio"/> M	__/__/____	<input type="radio"/> Y <input type="radio"/> N	
Child / Dependent		<input type="radio"/> F <input type="radio"/> M	__/__/____	<input type="radio"/> Y <input type="radio"/> N	
Child / Dependent		<input type="radio"/> F <input type="radio"/> M	__/__/____	<input type="radio"/> Y <input type="radio"/> N	
Child / Dependent		<input type="radio"/> F <input type="radio"/> M	__/__/____	<input type="radio"/> Y <input type="radio"/> N	
Other (specify):		<input type="radio"/> F <input type="radio"/> M	__/__/____	<input type="radio"/> Y <input type="radio"/> 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 # (    )		
<b>Language:</b> <input type="radio"/> English <input type="radio"/> Spanish <input type="radio"/> Other	E-mail address	Occupation
Do you have a disability that affects your ability to communicate or read? <input type="radio"/> N <input type="radio"/> Y		
Employment status (check one) <input type="radio"/> Active <input type="radio"/> Retiree <input type="radio"/> COBRA/State Continuation	Annual salary \$	

**Prior / Existing Coverage: IMPORTANT - DO NOT** cancel any existing coverage until you receive written notification from Humana of your acceptance for coverage.

**Medical**

**1. Prior medical coverage during the past 18 months (individual or other group coverage)?**  N  Y

Prior medical insurance carrier name	Policy #	<b>Prior coverage type:</b> <input type="radio"/> Employee / Individual only <input type="radio"/> Employee / Individual and spouse <input type="radio"/> Employee / Individual and child(ren) <input type="radio"/> Family	Effective date __/__/____
			Term date __/__/____

**2. Other medical coverage in effect at the same time as this Humana coverage (individual or other group coverage)?**  N  Y

Other medical insurance carrier name	Policy #	<b>Other coverage type:</b> <input type="radio"/> Employee / Individual only <input type="radio"/> Employee / Individual and spouse <input type="radio"/> Employee / Individual and child(ren) <input type="radio"/> Family	Effective date __/__/____
			Term date __/__/____

**3. Medicare**

Employee / Individual coverage: <input type="radio"/> N <input type="radio"/> Y	Medicare ID	Effective date __/__/____	Term date __/__/____
Spouse coverage: <input type="radio"/> N <input type="radio"/> Y	Medicare ID	Effective date __/__/____	Term date __/__/____

Last name:

First name:

**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 #	<b>Prior coverage type:</b> <input type="radio"/> Employee / Individual only <input type="radio"/> Employee / Individual and spouse <input type="radio"/> Employee / Individual and child(ren) <input type="radio"/> Family
	Effective date __ / __ / ____	
Prior carrier phone # ( )	Term date __ / __ / ____	

**Coverage Options**

<b>Medical</b>	Group #:	Benefit #:	Class/Div:
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Coverage type:  Employee / Individual only  Employee / Individual and spouse  Employee / Individual and child(ren)  Family  No Coverage (complete waiver) **Plan name:**

<b>Health Savings Account</b>	Group #:	Benefit #:	Class/Div:
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**If you have medical coverage under another plan, you may not be eligible for an HSA. Please check with your tax advisor for details.**

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.

Do you elect the Health Savings Account?  N  Y (If no, complete waiver.) 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.

<b>Dental</b>	Group #:	Benefit #:	Class/Div:
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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:**

<b>Basic Life / AD&amp;D</b>	Group #:	Benefit #:	Class/Div:
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**Basic dependent life**  N  Y (If no, complete waiver.) Class (employer will provide you with this information, if needed)

<b>Voluntary Life / AD&amp;D</b>	Group #:	Benefit #:	Class/Div:
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**Voluntary employee / 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

<b>Vision</b>	Group #:	Benefit #:	Class/Div:
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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:**

<b>Short Term Disability</b>	Group #:	Benefit #:	Class:	Div:
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Short Term Disability  N  Y (If no, complete waiver.) Buy-up percent/amount \_\_\_\_\_

<b>Long Term Disability</b>	Group #:	Benefit #:	Class:	Div:
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Long Term Disability  N  Y (If no, complete waiver.) Buy-up percent/amount \_\_\_\_\_

Last name:

First name:

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

<b>Accident</b>	<b>Group #:</b>	<b>Benefit #:</b>	<b>Class:</b>	<b>Div:</b>
<input type="radio"/> Accident <input type="radio"/> N <input type="radio"/> Y		Benefit Level: <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4		
<b>Coverage type:</b> <input type="radio"/> Employee / Individual only <input type="radio"/> Employee / Individual and spouse <input type="radio"/> Employee / Individual and child(ren) <input type="radio"/> Family				
<input type="radio"/> Optional Hospital Intensive Care Unit Benefits Rider <input type="radio"/> \$150 <input type="radio"/> \$300 <input type="radio"/> \$450 <input type="radio"/> \$600		<input type="radio"/> Optional Fracture and Dislocation Benefits Rider <input type="radio"/> \$750 <input type="radio"/> \$1,500		
<input type="radio"/> Optional Accident Total Disability Benefits Rider: <b>Elimination Period:</b> <input type="radio"/> 1 Day <input type="radio"/> 7 Days <input type="radio"/> 14 Days <input type="radio"/> 30 Days <b>Elimination Benefit:</b> <input type="radio"/> \$400 <input type="radio"/> \$500 <input type="radio"/> \$600 <input type="radio"/> \$700 <input type="radio"/> \$800 <input type="radio"/> \$900 <input type="radio"/> \$1000				

<b>Accident - 2012</b>	<b>Group #:</b>	<b>Benefit #:</b>	<b>Class:</b>	<b>Div:</b>
<input type="radio"/> Accident <input type="radio"/> N <input type="radio"/> Y		Benefit Level: <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4		
<b>Coverage type:</b> <input type="radio"/> Employee / Individual only <input type="radio"/> Employee / Individual and spouse <input type="radio"/> Employee / Individual and child(ren) <input type="radio"/> Family				

<b>Disability Income Plus</b>	<b>Group #:</b>	<b>Benefit #:</b>	<b>Class:</b>	<b>Div:</b>
<input type="radio"/> Disability Income Covering Accident and Sickness <input type="radio"/> N <input type="radio"/> Y				Monthly Benefit \$
<b>Base Benefit Period:</b> <input type="radio"/> 3 Month <input type="radio"/> 6 Month <input type="radio"/> 1 Year <input type="radio"/> 2 Year <input type="radio"/> 3 Year <b>Base Elimination Period:</b> <input type="radio"/> 0/7 <input type="radio"/> 7/7 <input type="radio"/> 0/14 <input type="radio"/> 14/14 <input type="radio"/> 30/30 <input type="radio"/> 60/60 <input type="radio"/> 90/90 <input type="radio"/> 180/180 <input type="radio"/> 365/365				
<input type="radio"/> Disability Income Covering Accident and Sickness with Waiver of Elimination Period <input type="radio"/> N <input type="radio"/> Y				Monthly Benefit \$
<b>Base Benefit Period:</b> <input type="radio"/> 3 Month <input type="radio"/> 6 Month <input type="radio"/> 1 Year <input type="radio"/> 2 Year <input type="radio"/> 3 Year <b>Base Elimination Period:</b> <input type="radio"/> 0/7 <input type="radio"/> 7/7 <input type="radio"/> 0/14 <input type="radio"/> 14/14				

**Optional Disability Income Benefits:**  ICU / CCU Benefit  \$200  \$400  \$600  \$800  
 Physical Therapy Benefit  COBRA Rider  COBRA Monthly Benefit \$

<b>Level Term Life</b>	<b>Group #:</b>	<b>Benefit #:</b>	<b>Class:</b>	<b>Div:</b>
<input type="radio"/> Level Term Life / AD&D <input type="radio"/> N <input type="radio"/> Y		<b>Coverage type:</b> <input type="radio"/> Employee / Individual only <input type="radio"/> Spouse <input type="radio"/> Child(ren)		<b>Base Plan:</b> <input type="radio"/> 10-Year Term <input type="radio"/> 20-Year Term <b>Optional Benefit:</b> <input type="radio"/> Automatic Benefit Increase
Employee / Individual Benefit \$	Spouse Benefit \$	Child(ren) Benefit \$		

**If your employer or group has elected the critical illness rider, have you or any dependent had 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 \_\_\_\_\_

<b>Critical Illness</b>	<b>Group #:</b>	<b>Benefit #:</b>	<b>Class:</b>	<b>Div:</b>
<input type="radio"/> Critical Illness <input type="radio"/> N <input type="radio"/> Y		<b>Coverage type:</b> <input type="radio"/> Employee / Individual only <input type="radio"/> Employee / Individual and spouse <input type="radio"/> Employee / Individual and child(ren) <input type="radio"/> Family		
<input type="radio"/> Critical Illness and Cancer <input type="radio"/> N <input type="radio"/> Y				

**Optional Benefits:**  Automatic Benefit Increase  Health Screening  Return on Premium  Employee / Individual Benefit \$

**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 \_\_\_\_\_

<b>Group Lump Sum Cancer</b>	<b>Group #:</b>	<b>Benefit #:</b>	<b>Class:</b>	<b>Div:</b>
<input type="radio"/> Group Lump Sum Cancer <input type="radio"/> N <input type="radio"/> Y		<b>Coverage type:</b> <input type="radio"/> Employee / Individual only <input type="radio"/> Employee / Individual and spouse <input type="radio"/> Employee / Individual and child(ren) <input type="radio"/> 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  Base Benefit \$

Last name:

First name:

<b>Hospital Indemnity</b>	<b>Group #:</b>	<b>Benefit #:</b>	<b>Class:</b>	<b>Div:</b>
<input type="radio"/> Hospital Indemnity <input type="radio"/> N <input type="radio"/> Y		<b>Coverage type:</b> <input type="radio"/> Employee / Individual only <input type="radio"/> Employee / Individual and spouse <input type="radio"/> Employee / Individual and child(ren) <input type="radio"/> Family		
<b>Plan type:</b> <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4				
<b>Beneficiary Information for Life, Disability and Workplace Voluntary Benefits</b>				
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 workplace voluntary (excludes Accident) benefits and/or Life over the guarantee issue amount.**

<b>1a.</b>	In the past 12 months has any applicant used any tobacco product? If yes, applies to: <input type="radio"/> Employee <input type="radio"/> Spouse/Domestic Partner <input type="radio"/> Other <input type="radio"/> Child/Dependent names_____	<input type="radio"/> N <input type="radio"/> Y
<b>1b.</b>	Is any applicant currently a smoker? If yes, applies to: <input type="radio"/> Employee <input type="radio"/> Spouse/Domestic Partner <input type="radio"/> Other <input type="radio"/> Child/Dependent names_____	<input type="radio"/> N <input type="radio"/> Y
<b>2.</b>	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?	<input type="radio"/> N <input type="radio"/> Y
<b>3.</b>	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?	<input type="radio"/> N <input type="radio"/> Y
<b>4.</b>	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:	
<b>a.</b>	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)?	<input type="radio"/> N <input type="radio"/> Y
<b>b.</b>	Nervous, mental or emotional disorder; convulsions; epilepsy; unconsciousness; Multiple Sclerosis; Parkinson's Disease; Cerebral Palsy?	<input type="radio"/> N <input type="radio"/> Y
<b>c.</b>	Stroke; Transient Ischemic Attack (TIA)?	<input type="radio"/> N <input type="radio"/> Y
<b>d.</b>	Emphysema; asthma, or other disease of lungs, or respiratory organs?	<input type="radio"/> N <input type="radio"/> Y
<b>e.</b>	End stage renal disease; disease of kidney?	<input type="radio"/> N <input type="radio"/> Y
<b>f.</b>	Cancer, and/or cancerous tumor; including skin cancer?	<input type="radio"/> N <input type="radio"/> Y
<b>g.</b>	Diabetes; liver or thyroid disease; hepatitis; cirrhosis; or enlargement of the lymph nodes?	<input type="radio"/> N <input type="radio"/> Y
<b>h.</b>	Rheumatoid arthritis; or back disorders; or joint disorders?	<input type="radio"/> N <input type="radio"/> Y
<b>i.</b>	Paralysis, or any other physical impairment or deformity?	<input type="radio"/> N <input type="radio"/> Y
<b>j.</b>	Chronic Fatigue Syndrome/Fibromyalgia?	<input type="radio"/> N <input type="radio"/> Y
<b>k.</b>	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?	<input type="radio"/> N <input type="radio"/> Y
<b>l.</b>	Alcoholism or drug habit?	<input type="radio"/> N <input type="radio"/> Y
<b>5.</b>	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?	<input type="radio"/> N <input type="radio"/> Y

Last name:

First name:

**Evidence of Health Status - Do not submit more than 90 days prior to the effective date. (continued)**

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 TX-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 __ / __ / ____		

**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.

<p>I hereby waive coverage for (check all that apply):</p> <p>Medical for:                    <input type="radio"/> Myself    <input type="radio"/> My spouse    <input type="radio"/> My dependent child(ren)</p> <p>Dental for:                     <input type="radio"/> Myself    <input type="radio"/> My spouse    <input type="radio"/> My dependent child(ren)</p> <p>Basic Life for:                <input type="radio"/> Myself    <input type="radio"/> My spouse    <input type="radio"/> My dependent child(ren)</p> <p>Vision for:                     <input type="radio"/> Myself    <input type="radio"/> My spouse    <input type="radio"/> My dependent child(ren)</p> <p>Short Term Disability for:   <input type="radio"/> Myself</p> <p>Long Term Disability for:   <input type="radio"/> Myself</p> <p>Health Savings Account for: <input type="radio"/> Myself</p> <p><b>Waive Coverage for Workplace Voluntary Benefits:</b></p> <p>Level Term Life for:         <input type="radio"/> Myself    <input type="radio"/> My spouse    <input type="radio"/> My dependent child(ren)</p> <p>Critical Illness for:         <input type="radio"/> Myself    <input type="radio"/> My spouse    <input type="radio"/> My dependent child(ren)</p> <p>Group Lump Sum Cancer for: <input type="radio"/> Myself    <input type="radio"/> My spouse    <input type="radio"/> My dependent child(ren)</p> <p>Hospital Indemnity for:     <input type="radio"/> Myself    <input type="radio"/> My spouse    <input type="radio"/> My dependent child(ren)</p> <p>Accident for:                 <input type="radio"/> Myself    <input type="radio"/> My spouse    <input type="radio"/> My dependent child(ren)</p> <p>Disability Income Plus for: <input type="radio"/> Myself</p>	<p>I decline to apply for group coverage because of:</p> <p><input type="radio"/> Spousal coverage</p> <p><input type="radio"/> Medicare supplement</p> <p><input type="radio"/> Individual coverage</p> <p><input type="radio"/> Coverage under another carrier's plan provided by my employer / group</p> <p><input type="radio"/> Other: _____</p>
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## Agreement

### True and complete acknowledgement

I understand, agree, and represent:

- I have read the 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 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. 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 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.
- 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. I understand eligibility for enrollment does not apply to an 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 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 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 Application and Enrollment Form by Humana.
- For small employer groups, I understand that any misstatements of health status will not be used to cancel, non-renew or void my medical coverage under this policy or plan but may result in an increase in medical premiums following a written notice as required in the Policy or Group Contract.
- 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 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 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 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.)

Last name: \_\_\_\_\_

First name: \_\_\_\_\_

**Required Disclosure Notice for PPO & HMO Consumer Choice Benefit Plans for groups with 2-50 employees**

Below is the Required Disclosure Notice for Group PPO & 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 PPO 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 PPO State Mandates**

- TMJ
- Home Health Care
- Invitro
- Hearing Aid

**Excluded HMO State Mandates**

- TMJ
- Invitro

The Consumer Choice Health Benefit Plan may include requirements and/or restrictions on deductibles, coinsurance, copayments, or maximum benefit amounts that differ from other PPO & 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](http://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:**

Name (print) \_\_\_\_\_

Humana Agent # \_\_\_\_\_

Commission split: \_\_\_\_\_

**1. Writing Agent / Producer:**

Name (print) \_\_\_\_\_

Humana Agent # \_\_\_\_\_

Commission split: \_\_\_\_\_

**2. Agent / Agency of Record:**

Name (print) \_\_\_\_\_

Humana Agent # \_\_\_\_\_

Commission split: \_\_\_\_\_

**2. Writing Agent / Producer:**

Name (print) \_\_\_\_\_

Humana Agent # \_\_\_\_\_

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 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. 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 \_\_\_\_/\_\_\_\_/\_\_\_\_

Last name:

First name:

## 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				<input type="radio"/> N <input type="radio"/> Y
Spouse				<input type="radio"/> N <input type="radio"/> Y
Child				<input type="radio"/> N <input type="radio"/> Y
Child				<input type="radio"/> N <input type="radio"/> Y
Child				<input type="radio"/> N <input type="radio"/> Y
Other (specify)				<input type="radio"/> N <input type="radio"/> Y

### Primary Dentist Selection (for DHMO use only)

	Member Last name First name MI	Primary dentist name	Dentist ID	Current patient
Employee				<input type="radio"/> N <input type="radio"/> Y
Spouse				<input type="radio"/> N <input type="radio"/> Y
Child				<input type="radio"/> N <input type="radio"/> Y
Child				<input type="radio"/> N <input type="radio"/> Y
Child				<input type="radio"/> N <input type="radio"/> Y
Other (specify)				<input type="radio"/> N <input type="radio"/> 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				<input type="radio"/> N <input type="radio"/> Y
Spouse				<input type="radio"/> N <input type="radio"/> Y
Child				<input type="radio"/> N <input type="radio"/> Y
Child				<input type="radio"/> N <input type="radio"/> Y
Child				<input type="radio"/> N <input type="radio"/> Y
Other (specify):				<input type="radio"/> N <input type="radio"/> Y