Group Employee and Individual Application and Enrollment Form - 1-100 Employees Maryland

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 as "Humana".

Humana Insurance Company/HumanaDental Insurance Company • 1100 Employers Boulevard • DePere, WI 54115
CompBenefits Insurance Company • 100 Mansell East, Suite 400 • Roswell, GA 30076
Kanawha Insurance Company • 210 South White Street P.O. Box 610 Lancaster, SC 29721-0610

Life plans insured or administered by ☐ Humana Insurance Company. Dental plans insured or administered by ☐ HumanaDental Insurance Company. Vision plans insured or administered by ☐ CompBenefits Insurance Company or ☐ Humana Insurance Company. Short Term Disability,and Long Term Disability,and Life,and Workplace Voluntary Benefits 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 $

Prior / Existing Coverage:

IMPORTANT - DO NOT cancel any existing coverage until you receive written notification from Humana of your acceptance for coverage.

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 #	**Prior coverage type:**
	Effective date _ _ / _ _ / _ _ _ _	❍ Employee / Individual only ❍ Employee / Individual and spouse ❍ Employee / Individual and child(ren) ❍ Family
Prior carrier phone # ( )	Term date _ _ / _ _ / _ _ _ _	

Last name: | First name:

Coverage Options

Dental

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:

Basic Life / AD&D

Group #: | Benefit #: | Class/Div:

Basic dependent life ❍ N ❍ Y (If no, complete waiver.) | Class (employer will provide you with this information, if needed)

Voluntary Life / AD&D

Group #: | Benefit #: | Class/Div:

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

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:

Short Term Disability

Group #: | Benefit #: | Class: | Div:

Short Term Disability ❍ N ❍ Y (If no, complete waiver.) Buy-up percent/amount _____

Long Term Disability

Group #: | Benefit #: | Class: | Div:

Long Term Disability ❍ N ❍ Y (If no, complete waiver.) Buy-up percent/amount _____

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

Accident 8006

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

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

Monthly Benefit $

❍ Disability Income Covering Accident and Sickness with Waiver of Elimination Period ❍ 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

Optional Disability Income Benefits: ❍ ICU / CCU Benefit ❍ $200 ❍ $400 ❍ $600 ❍ $800

❍ Physical Therapy Benefit ❍ COBRA Rider | COBRA Monthly Benefit $

Last name:	First name:

Level Term Life	Group #:		Benefit #:		Class:		Div:	
❍ Level Term Life / AD&D ❍ N ❍ Y		**Coverage type:** ❍ Employee / Individual only ❍ Spouse ❍ Child(ren)			**Base Plan:** ❍10-Year Term ❍20-Year Term **Optional Benefit:** ❍ Automatic Benefit Increase			
Employee / Individual Benefit $		Spouse Benefit $			Child(ren) Benefit $			

Critical Illness	Group #:		Benefit #:		Class:		Div:	
❍ Critical Illness ❍ N ❍ Y ❍ Critical Illness and Cancer ❍ N ❍ Y		**Coverage type:** ❍ Employee / Individual only ❍ Employee / Individual and spouse ❍ Employee / Individual and child(ren) ❍ Family						
Optional Benefits: ❍ Automatic Benefit Increase ❍ Health Screening ❍ Return on Premium					Employee / Individual Benefit $			

Group Lump Sum Cancer	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						
Rider: ❍ Automatic Benefit Increase ❍ Health Screenings					Base Benefit $			

Supplemental Health	Group #:		Benefit #:		Class:		Div:	
❍ Supplemental Health ❍ N ❍ Y		**Coverage type:** ❍ Employee / Individual only ❍ Employee / Individual and spouse ❍ Employee / Individual and child(ren) ❍ Family						
Plan type: ❍ 1 ❍ 2 ❍ 3 ❍ 4								

Beneficiary Information for Life, Disability and Workplace Voluntary Benefits	
Primary beneficiary name (Last, First MI)	Relationship to Employee / Individual
Secondary beneficiary name (Last, First MI)	Relationship to Employee / Individual

Last name:	First name:

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).

1a.	In the past 12 months has any applicant used any tobacco product? If yes, applies to: ❍ Employee ❍ Spouse/Domestic Partner ❍ Other ❍ Child/Dependent names_____	❍ N ❍ Y
1b.	Is any applicant currently a smoker? If yes, applies to: ❍ Employee ❍ Spouse/Domestic Partner ❍ Other ❍ Child/Dependent names_____	❍ N ❍ Y
2.	In the past 12 months, have you missed 5 or more consecutive days of work due to an injury or known 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
3.	Within the last seven years, has anyone on this application been diagnosed or received treatment for an immune system disorder (i.e. Lupus, ITP), AIDS or an AIDS-related complex?	❍ N ❍ Y
4.	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	**g.**	Diabetes; liver or thyroid disease; hepatitis; cirrhosis; or enlargement of the lymph nodes?	❍ N ❍ Y
b.	Nervous, mental or emotional disorder; convulsions; epilepsy; unconsciousness; Multiple Sclerosis; Parkinson's Disease; Cerebral Palsy?	❍ N ❍ Y	**h.**	Rheumatoid arthritis; or back disorders; or joint disorders?	❍ N ❍ Y
c.	Stroke; Transient Ischemic Attack (TIA)?	❍ N ❍ Y	**i.**	Paralysis, or any other physical impairment or deformity?	❍ N ❍ Y
d.	Emphysema; asthma, or other disease of lungs, or respiratory organs?	❍ N ❍ Y	**j.**	Chronic Fatigue Syndrome/Fibromyalgia?	❍ N ❍ Y
e.	End stage renal disease; disease of kidney?	❍ N ❍ Y	**k.**	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
f.	Cancer, and/or cancerous tumor; including skin cancer?	❍ N ❍ Y	**l.**	Alcoholism or drug habit?	❍ N ❍ Y

5.	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

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 (form MD-72000), 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 _ _ / _ _ / _ _ _ _

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):

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		

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)
Supplemental Health for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Accident 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: _____

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.
- In the event that I should decide to apply for coverage hereafter, that subsequent 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 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 unless specifically required to be longer under certain circumstances indicated in your contract.
- 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 unless specifically required to be longer under certain circumstances indicated in your contract.
- Humana reserves the right to delay medical coverage and/or deny life or dental coverage with any future submissions of the Group Employee and Individual Application and Enrollment Form for coverage.
- If any deductions are required for this coverage, I authorize those deductions from my earnings.
- 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. Except that no change in amount, classification, plan of insurance, or benefits may take effect unless agreed to in writing by the applicant.
- 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.
- Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

If you decide not to sign this agreement, we will decline to enroll you in an insurance product or to give you insurance benefits.

Last name: | First name:

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 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 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.

Employee / Individual or legal representative signature: _____ Date: _____

Name and relationship of legal representative: _____

Spouse signature: _____ Date:_____

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 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.