Large Group 51+ Employee Enrollment Form — ILLINOIS

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in the Large Group 51+ Employee Enrollment Form as "Humana".

HMO plans offered by **Humana Health Plan, Inc.** PPO, Indemnity medical and Life plans insured or administered by **Humana Insurance Company**. Dental PPO, Preventative Plus and Traditional Preferred plans insured or administered by **HumanaDental Insurance Company** or **Humana Insurance Company**. Dental prepaid plans offered and administered by **CompBenefits Dental, Inc.** Vision plans insured or administered by **Humana Insurance Company** or **HumanaDental Insurance Company**.

Print clearly and completely fill in each applicable circle.

Employer / Group name

Employer / Group city

State

Qualifying Event Instructions

- ○ New business enrollment
- ○ New hire/Newly eligible
- ○ Dependent birth or adoption
- ○ Loss of coverage
- ○ Open Enrollment event
- ○ Rehire/Reinstatement
- ○ Marital status change
- ○ Other _____

Office use only

Qualifying event date (MM/DD/YYYY) ___ / ___ / ____

Benefit effective date (MM/DD/YYYY) ___ / ___ / ____

Employee / Individual information

Last name: HLADUN

First name: TARAS

MI

Social Security Number: 349 - 02 - 7614

Date of birth (MM/DD/YYYY): 07 / 18 / 1989

Area code: (773) Phone number: 744 - 7626

Street address: 6825 W. RAVEN ST

Apt / Suite / PO box number: 1 J

Gender ○ Female ☒ Male

Language of choice ☒ English ○ Spanish

City: CHICAGO

State: IL.

Zip code: 60631

County / Parish: COOK

E-mail address

Are you actively at work? ☒ Yes ○ No If not, reason:

○ Retiree ○ COBRA Other: _____

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: _____

Annual salary $ _____ Hours worked per week _____

Occupation: CAREGIVER

HMO/POS only — Primary care physician name: HONG CHEN — Primary care physician ID # _____ — Current patient? ○ Yes ○ No

HMO/POS only — OB/GYN Primary care physician name (if applicable) _____ — Primary care physician ID # _____ — Current patient? ○ Yes ○ No