Use the following alternate address for these dependents: ○ 1 ○ 2 ○ 3 ○ 4

Street address

Apt / Suite / PO box number

City | State | Zip code | County

3

Medical

Coverage type:
- ☒ Employee / / Individual only
- ○ Employee / / Individual & spouse
- ○ Employee / / Individual & child(ren)
- ○ Family
- ○ Other

Office use only
Group # | Benefit # | Class/Div #

Plan name IL 100 Smpcty HMO16 Network name ADVOCATE

Do you or any covered dependent(s) currently have other medical coverage, such as a spouse's plan, another Humana medical plan, or Medicare? ○ Yes ☒ No If yes, list all: (This section must be completed for Humana to process any medical claims.)

Medicare ID or medical carrier name:

Starting date (MM/DD/YYYY) / /

End date, if applicable (MM/DD/YYYY) / /

Coverage Type (check all that apply)
- ○ Employee / Individual
- ○ Spouse
- ○ Child(ren)

Medicare ID or medical carrier name:

Starting date (MM/DD/YYYY) / /

End date, if applicable (MM/DD/YYYY) / /

Coverage Type (check all that apply)
- ○ Employee / Individual
- ○ Spouse
- ○ Child(ren)

Have you or any covered dependent(s) had medical insurance from a company (including another Humana plan) in the past 18 months? ☒ Yes ○ No If yes, list all: (This section must be completed for Humana to process any medical claims.)

Prior medical carrier name: HUMANA

Starting date (MM/DD/YYYY) 01 / 01 / 2020

End date, if applicable (MM/DD/YYYY) 12 / 31 / 2020

Coverage Type (check all that apply)
- ☒ Employee / Individual
- ○ Spouse
- ○ Child(ren)

Prior medical carrier name:

Starting date (MM/DD/YYYY) / /

End date, if applicable (MM/DD/YYYY) / /

Coverage Type (check all that apply)
- ○ Employee / Individual
- ○ Spouse
- ○ Child(ren)

Medical Health History (for 51-100 groups) - Do not submit more than 90 days prior to the effective date

1. Within the past 24 months have you or any dependent to be covered had or been treated for an illness or injury, had surgery or hospitalization recommended? ☒ N ○ Y
2. Within the past 24 months have you or any dependent to be covered been prescribed medication? ☒ N ○ Y
3. Have you or any dependent to be covered incurred medical expenses in excess of $7,500 in the past 12 months? ☒ N ○ Y

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 IL-51340-MH), if necessary.

Question# | Person Treated Last name | First Name

Condition | Treatments received

Medications | Current or future treatments or medications

Date diagnosed (MM/DD/YYYY) / /

Date last seen by a doctor (MM/DD/YYYY) / /