Health Savings Account (HSA) Applicable only with High Deductible Health Plan selection

Do you elect the Health Savings Account?
○ Yes ☒ No If no, complete waiver section

If you have medical coverage under another plan, you may not be eligible for an HSA. Please check with your tax advisor for details.

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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.

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.

Flexible Spending Account (FSA)

Do you elect the flexible health account?
○ Yes ☒ No If no, complete waiver section

Annual amount elected:
$ [ ][ ] , [ ][ ][ ] .00

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FSA HC

Start date (MM/DD/YYYY) [ ][ ] / [ ][ ] / [ ][ ][ ][ ]

End date (MM/DD/YYYY) [ ][ ] / [ ][ ] / [ ][ ][ ][ ]

Do you elect the flexible dependent health account? ○ Yes ○ No If no, complete waiver section

Annual amount elected:
$ [ ][ ] , [ ][ ][ ] .00

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FSA DC

Start date (MM/DD/YYYY) [ ][ ] / [ ][ ] / [ ][ ][ ][ ]

End date (MM/DD/YYYY) [ ][ ] / [ ][ ] / [ ][ ][ ][ ]

4

Dental

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

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Plan name ILH005MPCTYHMO160PT172

Within the past 12 months, have you or any covered family individual had any dental or orthodontia coverage, such as a spouse's dental coverage? ☒ Yes ○ No If yes, list all: (This section must be completed for Humana to process any dental claims)

Current dental carrier name:	Orthodontia coverage?	Starting date (MM/DD/YYYY)	End date, if applicable (MM/DD/YYYY)
HUMANA	○ Yes ☒ No	01 / 01 / 2020	12 / 31 / 2020

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

Prior dental carrier name:	Orthodontia coverage?	Starting date (MM/DD/YYYY)	End date, if applicable (MM/DD/YYYY)
	○ Yes ○ No	/ /	/ /

Coverage type check all that apply)
○ Employee / Individual only
○ Employee / Individual and child(ren)
○ Employee / Individual and spouse
○ Family

	Employee primary care dentist name	Dentist ID #	Current patient?
DHMO			○ Yes ○ No
	Dependent primary care dentist name	Dentist ID #	Current patient?
1 DHMO			○ Yes ○ No
2 DHMO			○ Yes ○ No
3 DHMO			○ Yes ○ No