

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

HMO plans offered by Humana Health Plan of Ohio, Inc. POS plans offered by Humana Health Plan of Ohio, Inc. and insured or administered by Humana Insurance Company. PPO and Classic medical plans and Life and Short-Term Income Protection plans insured or administered by Humana Insurance Company. Dental plans insured or administered by HumanaDental Insurance Company or Humana Insurance Company.

Please print clearly and fill in each applicable circle.

Group number \_\_\_\_\_ Benefit number \_\_\_\_\_ Class/Division \_\_\_\_\_

**Employee Information**

Last name \_\_\_\_\_ First name \_\_\_\_\_ MI \_\_\_\_\_

Social Security number \_\_\_\_\_ Employer Name \_\_\_\_\_

**Change Employee Address Information**

New street address \_\_\_\_\_ Apt / Suite / PO Box number \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_ County \_\_\_\_\_

Email address \_\_\_\_\_ Phone number \_\_\_\_\_

**Change or Select Primary Care Physician (HMO and POS only)**

Employee's primary care physician \_\_\_\_\_ Physician ID \_\_\_\_\_

Dependent last name \_\_\_\_\_ First name \_\_\_\_\_ MI \_\_\_\_\_

Dependent's primary care physician \_\_\_\_\_ Physician ID \_\_\_\_\_

**Change Plans or Dependents**

- Change plan from \_\_\_\_\_ to \_\_\_\_\_  
If changing to an HMO or POS plan, please select a primary care physician and enter above.
- Change benefit/class to: Benefit number: \_\_\_\_\_ Class/Division: \_\_\_\_\_
- Add dependent (complete Dependent Information form and any applicable enrollment forms)
- Delete dependent (complete Dependent Information form and any applicable enrollment forms)
- Cancel coverage: Termination date (MMDDYYYY): \_\_\_\_\_

Indicate qualifying event:		
<input type="radio"/> Re-hire	<input type="radio"/> Divorce	<input type="radio"/> Dependent birth / adoption
<input type="radio"/> Legal separation	<input type="radio"/> Spouse's employer terminates coverage	<input type="radio"/> Other:
<input type="radio"/> Employer contribution ceases	<input type="radio"/> Spouse deceased	<b>Qualifying event date (MMDDYYYY):</b>
<input type="radio"/> Spouse changes from full-time to part-time employment	<input type="radio"/> Spouse terminates employment	

**Change Beneficiary**

**Basic Life:** Primary beneficiary name \_\_\_\_\_ Secondary beneficiary name \_\_\_\_\_

**Voluntary Life:** Primary beneficiary name \_\_\_\_\_ Secondary beneficiary name \_\_\_\_\_

**Dependent Information** OH-80124-DP 5/2006

1. Last name \_\_\_\_\_ First name \_\_\_\_\_ MI \_\_\_\_\_ Date of birth \_\_\_\_\_

Social Security number \_\_\_\_\_ Gender:  Female  Male Relationship:  Spouse  Child  Other: \_\_\_\_\_

Dependent status (if applicable):  Full-time student  Disabled If disabled, indicate reason: \_\_\_\_\_

**HMO and POS only:**

Primary care physician \_\_\_\_\_ Physician ID \_\_\_\_\_ Current Patient:  No  Yes

## Dependent Information (continued)

2. Last name	First name	MI	Date of birth
Social Security number	Gender: <input type="radio"/> Female <input type="radio"/> Male	Relationship: <input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other:	
Dependent status (if applicable): <input type="radio"/> Full-time student <input type="radio"/> Disabled	If disabled, indicate reason:		

### HMO and POS only:

Primary care physician \_\_\_\_\_ Physician ID \_\_\_\_\_ Current Patient:  No  Yes

## Agreement

OH-80124-AA 5/2006

### True and complete acknowledgement

I understand, agree and represent:

- I have read this document or it has been read to me.
- The answers provided within this entire application for coverage are to the best of my knowledge and belief, true and complete.
- Neither my employer nor the agent has the authority to waive a complete answer to any question, determine coverage or insurability, alter any contract, or waive any of Humana's other rights and requirements.
- If this application for coverage is accepted, coverage will be effective on the date specified by Humana on the certificate of coverage/certificate of insurance.
- Any misrepresentation contained herein relied on by Humana may be used to reduce or deny a claim or void the contract within the contestable period if such misrepresentation materially affected the acceptance of the risk.
- Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer or health maintenance organization, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

I hereby enroll for benefits for which I am presently eligible or for which I may become eligible under my employer's group contract(s). If any deductions are required for this coverage, I authorize such deductions from my earnings. I reserve the right to revoke this deduction authorization at any time upon written notice unless I have chosen to use pretax deductions.

This document, together with any supplements, will form part of any contract and be the basis for any certificate of coverage/certificate of insurance issued.

### Authorization

My dependents and I authorize any physician, medical or health care practitioner, hospital, clinic, veterans administration facility, other medical or medically-related facility, third party administrator, Pharmacy Benefit Manager, insurance, HMO or reinsuring company, the Medical Information Bureau, Inc., employer, the Consumer Reporting Agency or banking and financial institutions having information regarding myself and my dependents, including information concerning, advice, diagnosis, treatment and care of the physical, psychiatric, mental or emotional

conditions, drug, substance or alcohol abuse, illness, and copies of all hospital or medical records, non-public personal health information, and any other non-medical information to share any and all such information with Humana, its reinsurer or its legal representatives, and its affiliates.

### My dependents and I understand and agree:

- The information obtained by use of this authorization may be used by Humana to determine eligibility for coverage, eligibility for benefits under an existing policy, plan administration, and make claim determinations.
- If you decide not to sign this authorization, Humana can not complete your plan enrollment or determine your premium rate due to the inability to obtain the necessary information.
- If selecting the Health Savings Account (HSA), you authorize Humana or our banking partners to provide your account number to your employer for the purposes of depositing any contributions.
- 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 an application, claim or as may be otherwise lawfully required, or as I (we) may further authorize.
- Once personal and health (including medical, dental and pharmacy) information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal and state privacy requirements.
- A copy of this authorization is available to me or my legal representative upon written request.
- A photographic copy of this authorization shall be as valid as the original.
- This authorization shall be valid for two years from the date shown below.
- I have the right to revoke this authorization at any time:
  - To revoke this authorization, I must do so in writing and send my written revocation to Humana's Privacy Office.
  - The revocation will not apply to information that has already been released in response to this authorization.
  - The revocation will become effective after it is received by Humana's Privacy Office.

## State Notices

**Warning:** If you or your family members are covered by more than one health care plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors, dentists, and hospitals, and it may be impossible to comply with both plans at the same time. Before you enroll in this plan, read all of the rules very carefully and compare them with the rules of any other plan that covers you or your family.

**Notice of Cancellation:** If you are obligated for any part of a premium rate in connection with enrollment in this health plan, in addition to any right otherwise available to revoke an offer, you may cancel such agreement within 72 hours after having signed an enrollment form. Cancellation occurs when written notice of cancellation is mailed to Humana, its representatives or the employer (Ohio HMO and POS plans only).

## Signature - please sign below if enrolling or waiving group coverage

Employee or legal representative signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name and relationship of legal representative: \_\_\_\_\_

Spouse signature: \_\_\_\_\_ Date: \_\_\_\_\_