

**Group Employee and Individual Application and Enrollment Form - 1-100 Employees Florida**

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". To elect primary care physician or dentist, please complete reorder FL-51340-PP.

PPO, EPO and Indemnity plans insured by Humana Health Insurance Company of Florida, Inc. POS and HMO plans offered by Humana Medical Plan, Inc. Humana National POS plan insured by Humana Health Insurance Company of Florida, Inc. and offered by Humana Medical Plan, Inc. Life plans insured or administered by Humana Insurance Company. Prepaid, Basic, Intermediate and High Dental plans underwritten by The Dental Concern, Inc. Prepaid and AdvantagePlus Dental plans offered and administered by CompBenefits Company. All other Dental plans insured or administered by HumanaDental Insurance Company or Humana Insurance Company. Vision plans insured or administered by Humana Insurance Company or CompBenefits Insurance Company or CompBenefits Company. Short Term Disability, Long Term Disability, Life and Workplace Voluntary 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
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**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		<input type="radio"/> F <input type="radio"/> M	__/__/____	<input type="radio"/> Y <input type="radio"/> N	N/A (complete in Employee/ Individual Information section.)
Spouse / Domestic Partner		<input type="radio"/> F <input type="radio"/> M	__/__/____	<input type="radio"/> Y <input type="radio"/> N	
Child / Dependent		<input type="radio"/> F <input type="radio"/> M	__/__/____	<input type="radio"/> Y <input type="radio"/> N	
Child / Dependent		<input type="radio"/> F <input type="radio"/> M	__/__/____	<input type="radio"/> Y <input type="radio"/> N	
Child / Dependent		<input type="radio"/> F <input type="radio"/> M	__/__/____	<input type="radio"/> Y <input type="radio"/> N	
Other (specify):		<input type="radio"/> F <input type="radio"/> M	__/__/____	<input type="radio"/> Y <input type="radio"/> N	

<b>Employee / Individual Information</b>	<b>Hours worked per week:</b>	<b>Date of full time hire:</b> __/__/____
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Social Security Number	Street address	APT / Suite / Box
City	State	ZIP code
Phone # ( )		
<b>Language:</b> <input type="radio"/> English <input type="radio"/> Spanish <input type="radio"/> Other		E-mail address
Occupation		
Employment status (check one) <input type="radio"/> Active <input type="radio"/> Retiree <input type="radio"/> 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.

**Medical**

**1. Prior medical coverage during the past 18 months (individual or other group coverage)?**  N  Y

Prior medical insurance carrier name	Policy #	<b>Prior coverage type:</b> <input type="radio"/> Employee / Individual only <input type="radio"/> Employee / Individual and spouse <input type="radio"/> Employee / Individual and child(ren) <input type="radio"/> Family	Effective date __/__/____
			Term date __/__/____

**2. Other medical coverage in effect at the same time as this Humana coverage (individual or other group coverage)?**  N  Y

Other medical insurance carrier name	Policy #	<b>Other coverage type:</b> <input type="radio"/> Employee / Individual only <input type="radio"/> Employee / Individual and spouse <input type="radio"/> Employee / Individual and child(ren) <input type="radio"/> Family	Effective date __/__/____
			Term date __/__/____

**3. Medicare**

Employee / Individual coverage: <input type="radio"/> N <input type="radio"/> Y	Medicare ID	Effective date __/__/____	Term date __/__/____
Spouse coverage: <input type="radio"/> N <input type="radio"/> Y	Medicare ID	Effective date __/__/____	Term date __/__/____

Last name:

First name:

**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 #	<b>Prior coverage type:</b> <input type="radio"/> Employee / Individual only <input type="radio"/> Employee / Individual and spouse <input type="radio"/> Employee / Individual and child(ren) <input type="radio"/> Family
	Effective date __ / __ / ____	
Prior carrier phone # ( )	Term date __ / __ / ____	

**Whole Life**

Do you have existing life insurance policies or annuity contracts?  N  Y

Will any of the policies applied for replace any coverage currently in force?  N  Y

Prior life insurance carrier name	Policy #	<b>Prior coverage type:</b> <input type="radio"/> Employee / Individual only <input type="radio"/> Employee / Individual and spouse <input type="radio"/> Employee / Individual and child(ren) <input type="radio"/> Family
	Effective date __ / __ / ____	
Prior carrier phone # ( )	Term date __ / __ / ____	

**Coverage Options**

<b>Medical</b>	Group #:	Benefit #:	Class/Div:
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<b>Coverage type:</b>	<input type="radio"/> Employee / Individual only <input type="radio"/> Employee / Individual and spouse <input type="radio"/> Employee / Individual and child(ren) <input type="radio"/> Family <input type="radio"/> No Coverage (complete waiver)	<b>Plan name:</b>
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For medical plans only: Do you wish to extend coverage for your dependent adult child(ren) up to age 30?  No  Yes

<b>Health Savings Account</b>	Group #:	Benefit #:	Class/Div:
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**If you have medical coverage under another plan, you may not be eligible for an HSA. Please check with your tax advisor for details.**

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.

Do you elect the Health Savings Account?  N  Y (If no, complete waiver.) 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.

<b>Dental</b>	Group #:	Benefit #:	Class/Div:
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<b>Coverage type:</b>	<input type="radio"/> Employee / Individual only <input type="radio"/> Employee / Individual and spouse <input type="radio"/> Employee / Individual and child(ren) <input type="radio"/> Family <input type="radio"/> No Coverage (complete waiver)	Rate Amount \$ _____ Rate Frequency (Monthly) Rate Amount \$ _____ Rate Frequency (Monthly) Rate Amount \$ _____ Rate Frequency (Monthly) Rate Amount \$ _____ Rate Frequency (Monthly)	<b>Plan name:</b>
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<b>Basic Life / AD&amp;D</b>	Group #:	Benefit #:	Class/Div:
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**Basic dependent life**  N  Y (If no, complete waiver.) Class (employer will provide you with this information, if needed)

<b>Voluntary Life / AD&amp;D</b>	Group #:	Benefit #:	Class/Div:
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**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

<b>Vision</b>	Group #:	Benefit #:	Class/Div:
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<b>Coverage type:</b>	<input type="radio"/> Employee / Individual only <input type="radio"/> Employee / Individual and spouse <input type="radio"/> Employee / Individual and child(ren) <input type="radio"/> Family <input type="radio"/> No Coverage (complete waiver)	Rate Amount \$ _____ Rate Frequency (Monthly) Rate Amount \$ _____ Rate Frequency (Monthly) Rate Amount \$ _____ Rate Frequency (Monthly) Rate Amount \$ _____ Rate Frequency (Monthly)	<b>Plan name:</b>
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<b>Short Term Disability</b>	Group #:	Benefit #:	Class:	Div:
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Short Term Disability  N  Y (If no, complete waiver.) Buy-up percent/amount \_\_\_\_\_

<b>Long Term Disability</b>	Group #:	Benefit #:	Class:	Div:
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Long Term Disability  N  Y (If no, complete waiver.) Buy-up percent/amount \_\_\_\_\_

Last name:

First name:

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

<b>Accident</b>	<b>Group #:</b>	<b>Benefit #:</b>	<b>Class:</b>	<b>Div:</b>
<input type="radio"/> Accident <input type="radio"/> N <input type="radio"/> Y				
Benefit Level: <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4				
<b>Coverage type:</b> <input type="radio"/> Employee / Individual only <input type="radio"/> Employee / Individual and spouse <input type="radio"/> Employee / Individual and child(ren) <input type="radio"/> Family				
<input type="radio"/> Optional Hospital Intensive Care Unit Benefits Rider <input type="radio"/> \$150 <input type="radio"/> \$300 <input type="radio"/> \$450 <input type="radio"/> \$600		<input type="radio"/> Optional Fracture and Dislocation Benefits Rider <input type="radio"/> \$750 <input type="radio"/> \$1,500		
<input type="radio"/> Optional Accident Total Disability Benefits Rider: <b>Elimination Period:</b> <input type="radio"/> 1 Day <input type="radio"/> 7 Days <input type="radio"/> 14 Days <input type="radio"/> 30 Days <b>Elimination Benefit:</b> <input type="radio"/> \$400 <input type="radio"/> \$500 <input type="radio"/> \$600 <input type="radio"/> \$700 <input type="radio"/> \$800 <input type="radio"/> \$900 <input type="radio"/> \$1000				

<b>Accident - 2012</b>	<b>Group #:</b>	<b>Benefit #:</b>	<b>Class:</b>	<b>Div:</b>
<input type="radio"/> Accident <input type="radio"/> N <input type="radio"/> Y				
Benefit Level: <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4				
<b>Coverage type:</b> <input type="radio"/> Employee / Individual only <input type="radio"/> Employee / Individual and spouse <input type="radio"/> Employee / Individual and child(ren) <input type="radio"/> Family				

<b>Disability Income Plus</b>	<b>Group #:</b>	<b>Benefit #:</b>	<b>Class:</b>	<b>Div:</b>
<input type="radio"/> Disability Income Covering Accident and Sickness <input type="radio"/> N <input type="radio"/> Y				
<b>Base Benefit Period:</b> <input type="radio"/> 3 Month <input type="radio"/> 6 Month <input type="radio"/> 1 Year <input type="radio"/> 2 Year <input type="radio"/> 3 Year				Monthly Benefit \$
<b>Base Elimination Period:</b> <input type="radio"/> 0/7 <input type="radio"/> 7/7 <input type="radio"/> 0/14 <input type="radio"/> 14/14 <input type="radio"/> 30/30 <input type="radio"/> 60/60				
<input type="radio"/> 90/90 <input type="radio"/> 180/180 <input type="radio"/> 365/365				
<input type="radio"/> Disability Income Covering Accident and Sickness with Waiver of Elimination Period <input type="radio"/> N <input type="radio"/> Y				
<b>Base Benefit Period:</b> <input type="radio"/> 3 Month <input type="radio"/> 6 Month <input type="radio"/> 1 Year <input type="radio"/> 2 Year <input type="radio"/> 3 Year				Monthly Benefit \$
<b>Base Elimination Period:</b> <input type="radio"/> 0/7 <input type="radio"/> 7/7 <input type="radio"/> 0/14 <input type="radio"/> 14/14				
<b>Optional Disability Income Benefits:</b> <input type="radio"/> ICU / CCU Benefit <input type="radio"/> \$200 <input type="radio"/> \$400 <input type="radio"/> \$600 <input type="radio"/> \$800				
<input type="radio"/> Physical Therapy Benefit		<input type="radio"/> COBRA Rider		COBRA Monthly Benefit \$

<b>Disability Income Advantage</b>	<b>Group #:</b>	<b>Benefit #:</b>	<b>Class:</b>	<b>Div:</b>
<input type="radio"/> Disability Income Advantage <input type="radio"/> N <input type="radio"/> Y				
<b>Base Benefit Period:</b> <input type="radio"/> 3 Month <input type="radio"/> 6 Month <input type="radio"/> 1 Year <input type="radio"/> 2 Year <input type="radio"/> 3 Year				Monthly Benefit \$
<b>Base Elimination Period:</b> <input type="radio"/> 0/7 <input type="radio"/> 7/7 <input type="radio"/> 0/14 <input type="radio"/> 14/14 <input type="radio"/> 30/30 <input type="radio"/> 60/60				
<input type="radio"/> 90/90 <input type="radio"/> 180/180 <input type="radio"/> 365/365				

Optional Riders: <input type="radio"/> Hospital Confinement <input type="radio"/> COBRA Rider	COBRA Monthly Benefit \$
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<b>Whole Life / AD&amp;D</b>	<b>Group #:</b>	<b>Benefit #:</b>	<b>Class:</b>	<b>Div:</b>
<input type="radio"/> Whole Life / AD&D <input type="radio"/> N <input type="radio"/> Y				
<input type="radio"/> Whole Life 99	<input type="radio"/> Whole Life 65	Employee / Individual Benefit \$		
<input type="radio"/> AD&D Rider <input type="radio"/> Automatic Premium Loan Option				
<input type="radio"/> Automatic Benefit Increase Rider <input type="radio"/> \$1 / Week <input type="radio"/> \$2 / Week		<input type="radio"/> Employee / Individual Term Rider to 65 Employee / Individual Benefit \$	<input type="radio"/> Family Term Rider Spouse Benefit \$    Child(ren) Benefit \$	

<b>Whole Life Spouse / AD&amp;D</b>	<b>Group #:</b>	<b>Benefit #:</b>	<b>Class:</b>	<b>Div:</b>
<input type="radio"/> Stand Alone Spouse / AD&D <input type="radio"/> N <input type="radio"/> Y				
<input type="radio"/> Whole Life 99	<input type="radio"/> Whole Life 65	Spouse Benefit \$		
<input type="radio"/> AD&D Rider	<input type="radio"/> Family Term Rider (Child Coverage Only) Child(ren) Benefit Amount \$		<input type="radio"/> Automatic Premium Loan Option	

Last name:

First name:

**Whole Life Child(ren) / AD&D** Group #: Benefit #: Class: Div:

Whole Life Child(ren) / AD&D  N  Y

**Child(ren) listed here must also be included as dependents under the Enrollment Information section of this application.**

N  Y **Coverage on Child 1** Child 1 Name Child 1 Benefit \$

N  Y **Coverage on Child 2** Child 2 Name Child 2 Benefit \$

N  Y **Coverage on Child 3** Child 3 Name Child 3 Benefit \$

**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 \$

**If your employer or group has elected the critical illness rider, to the best of your knowledge, have you or any dependent had a parent, brother, or sister with a history of heart attack, heart disease, stroke, or cancer diagnosis prior to age 60 ?**  N  Y

If yes, please indicate whether this applies to you (Employee / Individual), your spouse or a dependent.

You (Employee / Individual)  Spouse  Dependent Name \_\_\_\_\_

**Critical Illness (Individual)** Group #: Benefit #: Class: Div:

Critical Illness  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 \$

**Does anyone on this application have a parent, brother, or sister with a history of heart attack, heart disease, stroke, or cancer diagnosis prior to age 60?**  N  Y If yes, please indicate whether this applies to you (Employee / Individual), your spouse or a dependent.

You (Employee / Individual)  Spouse  Dependent Name \_\_\_\_\_

**Individual 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

**Does anyone on this application have a parent, brother, or sister with a history of cancer diagnosis prior to age 60 ?**  N  Y If yes, please indicate whether this applies to you (Employee / Individual), your spouse or a dependent.

You (Employee / Individual)  Spouse  Dependent Name \_\_\_\_\_

**Rider:**  Automatic Benefit Increase  Health Screenings Base Benefit \$

**Cancer Expense** Group #: Benefit #: Class: Div:

Cancer Expense  N  Y **Coverage type:**  Employee / Individual only  Employee / Individual and spouse  Employee / Individual and child(ren)  Family

Lump Sum Benefit (Equal to 50% of Base Benefit Amount) **Rider:**  Hospital Indemnity Rider Base Benefit \$

**Supplemental Health (Individual)** 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, Group Cancer and Group Disability Income) and/or life benefits or are a late enrollee.**

<b>1a.</b>	In the past 12 months has any applicant used any tobacco product? If yes, applies to: <input type="radio"/> Employee <input type="radio"/> Spouse/Domestic Partner <input type="radio"/> Other <input type="radio"/> Child/Dependent names _____	<input type="radio"/> N <input type="radio"/> Y
<b>1b.</b>	Is any applicant currently a smoker? If yes, applies to: <input type="radio"/> Employee <input type="radio"/> Spouse/Domestic Partner <input type="radio"/> Other <input type="radio"/> Child/Dependent names _____	<input type="radio"/> N <input type="radio"/> Y
<b>2.</b>	In the past 12 months, have you missed 5 or more consecutive days of work due to an injury or illness other than as a result of a cold, the flu, back problems, strained/sprained/fractured/broken limb or as a result of pregnancy?	<input type="radio"/> N <input type="radio"/> Y
<b>3.</b>	Has anyone on this application been tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection?	<input type="radio"/> N <input type="radio"/> Y
<b>4.</b>	Within the past 5 years, has anyone on this application been diagnosed by a licensed medical provider with diseases or conditions related to, counseled, consulted, or treated by a physician or licensed medical provider, including surgery, for any of the following:	

<b>a.</b>	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)?	<input type="radio"/> N <input type="radio"/> Y
<b>b.</b>	Nervous, mental or emotional condition; convulsions; epilepsy; unconsciousness; Multiple Sclerosis; Parkinson's Disease; Cerebral Palsy?	<input type="radio"/> N <input type="radio"/> Y
<b>c.</b>	Stroke; Transient Ischemic Attack (TIA)?	<input type="radio"/> N <input type="radio"/> Y
<b>d.</b>	Emphysema; asthma, or other disease of lungs, or respiratory organs?	<input type="radio"/> N <input type="radio"/> Y
<b>e.</b>	End stage renal disease; disease of kidney?	<input type="radio"/> N <input type="radio"/> Y
<b>f.</b>	Cancer, and/or cancerous tumor; including skin cancer?	<input type="radio"/> N <input type="radio"/> Y

<b>g.</b>	Diabetes; liver or thyroid disease; hepatitis; cirrhosis; or enlargement of the lymph nodes?	<input type="radio"/> N <input type="radio"/> Y
<b>h.</b>	Rheumatoid arthritis; or back conditions or joint conditions?	<input type="radio"/> N <input type="radio"/> Y
<b>i.</b>	Paralysis, or any other physical impairment or deformity?	<input type="radio"/> N <input type="radio"/> Y
<b>j.</b>	Chronic Fatigue Syndrome/Fibromyalgia?	<input type="radio"/> N <input type="radio"/> Y
<b>k.</b>	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?	<input type="radio"/> N <input type="radio"/> Y
<b>l.</b>	Alcoholism or drug habit?	<input type="radio"/> N <input type="radio"/> Y

<b>5.</b>	Has anyone on this application been advised by a licensed medical provider to have any diagnostic test, hospitalization, or surgery that has not been completed within the past 5 years?	<input type="radio"/> N <input type="radio"/> Y
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Last name:

First name:

**Medical Health History - Do not submit more than 90 days prior to the effective date.**

**Complete this section for individuals, including dependents, enrolling for medical (groups 51+) coverage. New employees enrolling in existing group coverage are not required to complete this section.**

1.	To the best of your knowledge and belief, is anyone on this application currently pregnant? If yes, please indicate anticipated delivery date below. Anticipated delivery date:	<input type="radio"/> N <input type="radio"/> Y
2.	In the past 12 months, have you missed 5 or more consecutive days of work due to an injury or illness other than as a result of a cold, the flu, back problems, strained/sprained/fractured/broken limb or as a result of pregnancy?	<input type="radio"/> N <input type="radio"/> Y
3.	Has anyone on this application been tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection?	<input type="radio"/> N <input type="radio"/> Y
4.	Is anyone on this application currently taking any prescribed medication by a licensed medical provider, or do you periodically take prescription medication for a recurrent condition?	<input type="radio"/> N <input type="radio"/> Y
5.	During the last 24 months, has anyone on this application been diagnosed by a licensed medical provider with, or treated for, any illness or injury or had surgery or hospitalization recommended?	<input type="radio"/> N <input type="radio"/> Y
6.	Within the past 12 months, has anyone on this application incurred medical expenses in excess of \$10,000?	<input type="radio"/> N <input type="radio"/> Y

Relationship	Last name, First name MI	Height (ft / in)	Weight (lbs)
Employee		/	
Spouse / Domestic Partner		/	
Child / Dependent		/	
Child /Dependent		/	
Child /Dependent		/	
Other (specify):		/	

**Excluding HIV/AIDS/ARC, 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 FL-51340-MH), if necessary.**

Question #	Person treated (Last name, First name)
Condition	Treatments received
Medications prescribed	Scheduled treatments or medications
Date diagnosed __ / __ / ____	Date last seen by a doctor __ / __ / ____

Last name: \_\_\_\_\_

First name: \_\_\_\_\_

**Waiver (refusal of coverage)**

<p>I hereby waive coverage for (check all that apply):</p> <p>Medical for:                    <input type="radio"/> Myself    <input type="radio"/> My spouse    <input type="radio"/> My dependent child(ren)</p> <p>Dental for:                    <input type="radio"/> Myself    <input type="radio"/> My spouse    <input type="radio"/> My dependent child(ren)</p> <p>Basic Life for:                <input type="radio"/> Myself    <input type="radio"/> My spouse    <input type="radio"/> My dependent child(ren)</p> <p>Vision for:                    <input type="radio"/> Myself    <input type="radio"/> My spouse    <input type="radio"/> My dependent child(ren)</p> <p>Short Term Disability for:    <input type="radio"/> Myself</p> <p>Long Term Disability for:    <input type="radio"/> Myself</p> <p>Health Savings Account for: <input type="radio"/> Myself</p> <p><b>Waive Coverage for Workplace Voluntary Benefits:</b></p> <p>Whole Life for:                <input type="radio"/> Myself    <input type="radio"/> My spouse    <input type="radio"/> My dependent child(ren)</p> <p>Level Term Life for:         <input type="radio"/> Myself    <input type="radio"/> My spouse    <input type="radio"/> My dependent child(ren)</p> <p>Critical Illness for:         <input type="radio"/> Myself    <input type="radio"/> My spouse    <input type="radio"/> My dependent child(ren)</p> <p>Group Lump Sum Cancer for: <input type="radio"/> Myself    <input type="radio"/> My spouse    <input type="radio"/> My dependent child(ren)</p> <p>Cancer Expense for:         <input type="radio"/> Myself    <input type="radio"/> My spouse    <input type="radio"/> My dependent child(ren)</p> <p>Supplemental Health for:    <input type="radio"/> Myself    <input type="radio"/> My spouse    <input type="radio"/> My dependent child(ren)</p> <p>Accident for:                 <input type="radio"/> Myself    <input type="radio"/> My spouse    <input type="radio"/> My dependent child(ren)</p> <p>Disability Income Plus for:   <input type="radio"/> Myself</p> <p>Disability Income Advantage for: <input type="radio"/> Myself</p>	<p>I decline to apply for group coverage because of:</p> <p><input type="radio"/> Spousal coverage</p> <p><input type="radio"/> Medicare supplement</p> <p><input type="radio"/> Individual coverage</p> <p><input type="radio"/> Coverage under another carrier's plan provided by my employer / group</p> <p><input type="radio"/> Other: _____</p>
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**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.
  - If I or my dependents become eligible for premium or rate subsidies under Medicaid or the Children's Health Insurance Program (CHIP), I may in the future be able to enroll myself or my dependents provided I request enrollment within 60 days after the qualifying event. I understand eligibility for enrollment does not apply to a High Deductible Health Plan (HDHP).
  - 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.
  - 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. I understand eligibility for enrollment does not apply to an HDHP.
  - 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.
  - If any deductions are required for this coverage, I authorize those deductions from my earnings. If selecting the Health Savings Account (HSA), I authorize Humana or its banking partners to provide my account number to my employer / group for the purposes of depositing any contributions.
  - 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.
  - 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 willingly and knowingly submits the Group Employee and Individual Application and Enrollment Form containing a false, incomplete or deceptive statement may be guilty of insurance fraud.

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. This authorization is valid for 24 months and can be revoked at any time. The signature is true and accurate.

**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.**

Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

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

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

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

(Only if selecting Life coverage over the guarantee issue amount.)

**Agent / Producer Information**

**If applying for workplace voluntary benefits, this section to be completed by Agent or Producer.**

**1. Agent / Agency of Record:**

Name (print) \_\_\_\_\_

Humana Agent # \_\_\_\_\_

Florida License ID # \_\_\_\_\_

Commission split: \_\_\_\_\_

**2. Agent / Agency of Record:**

Name (print) \_\_\_\_\_

Humana Agent # \_\_\_\_\_

Florida License ID # \_\_\_\_\_

Commission split: \_\_\_\_\_

**1. Writing Agent / Producer:**

Name (print) \_\_\_\_\_

Humana Agent # \_\_\_\_\_

Florida License ID # \_\_\_\_\_

Commission split: \_\_\_\_\_

**2. Writing Agent / Producer:**

Name (print) \_\_\_\_\_

Humana Agent # \_\_\_\_\_

Florida License ID # \_\_\_\_\_

Commission split: \_\_\_\_\_

**Agent replacement question:**

**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 \_\_\_\_/\_\_\_\_/\_\_\_\_