

Small Group Employee Enrollment Form - 1-50 Employees**MISSOURI**

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

- ☐ PPO and Indemnity Medical plans insured or administered by Humana Insurance Company.
☐ Dental plans insured or administered by Humana Dental Insurance Company or Humana Insurance Company.
☐ Vision plans insured or administered by Humana Dental Insurance Company or Humana 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	

Employee / Individual Information

Hours worked per week:

Date of full time hire: __/__/____

Social Security Number	Street address	APT / Suite / Box
City	State	ZIP code
Language: <input type="radio"/> English <input type="radio"/> Spanish <input type="radio"/> Other	E-mail address	Phone # ()
Are you actively at work? <input type="radio"/> Y <input type="radio"/> N	If not, reason: <input type="radio"/> Retiree <input type="radio"/> COBRA Other: _____	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 #	Prior coverage type: <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 #	Other coverage type: <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:

Dental1. Prior dental coverage during the past 12 months (individual or other group coverage)? ☐ N ☐ Y2. Prior orthodontia coverage in the past 12 months? ☐ N ☐ Y

Prior dental insurance carrier name	Policy #	Prior coverage type: <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

Medical	Group #:	Benefit #:	Class/Div:
Coverage type: <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)			Plan name:

Health Savings Account	Group #:	Benefit #:	Class/Div:
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? <input type="radio"/> N <input type="radio"/> Y (If no, complete waiver.)		Beneficiary for this account will be the employees / individual's estate. You may change beneficiary information on file with the bank that administers the HSA once the account is established.	

Dental	Group #:	Benefit #:	Class/Div:
Coverage type: <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)	Plan name:

Vision	Group #:	Benefit #:	Class/Div:
Coverage type: <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)	Plan name:

Beneficiary Information

Primary beneficiary name (Last, First MI)	Relationship to Employee / Individual
Secondary beneficiary name (Last, First MI)	Relationship to Employee / Individual

Waiver (refusal of coverage)

I acknowledge that I have been given the opportunity to apply for group coverage available to me and my dependents through my employer / group. I proclaim that I was not pressured or forced by my employer / group, the writing agent, or Humana into waiving (declining) coverage. If I have waived any coverage offered to me or my dependents, my signature is evidence of this action.

I hereby waive coverage for (check all that apply): Medical for: <input type="radio"/> Myself <input type="radio"/> My spouse <input type="radio"/> My dependent child(ren) Dental for: <input type="radio"/> Myself <input type="radio"/> My spouse <input type="radio"/> My dependent child(ren) Vision for: <input type="radio"/> Myself <input type="radio"/> My spouse <input type="radio"/> My dependent child(ren) Health Savings Account for: <input type="radio"/> Myself	I decline to apply for group coverage because of: <input type="radio"/> Spousal coverage <input type="radio"/> Medicare supplement <input type="radio"/> Individual coverage <input type="radio"/> Coverage under another carrier's plan provided by my employer / group <input type="radio"/> Other: _____
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Last name:

First name:

Agreement

True and complete acknowledgment

I understand, agree, and represent:

- I have read the Small Group Employee 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 Small Group Employee 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.
- In the event that I should decide to apply for coverage hereafter, that subsequent Small Group Employee 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.
- Based on the coverage I have elected, I may be required to furnish evidence of health status satisfactory to Humana.
- 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.
- 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.
- Humana reserves the right to delay medical coverage and/or deny life or dental coverage with any future submissions of the Small Group Employee Enrollment Form for coverage.
- 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 Small Group Employee Enrollment Form.
- 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 reduce an individual's or group's coverage or may increase past premium.
- 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 Small Group Employee Enrollment Form by Humana.
- Any person who willingly and knowingly submits the Small Group Employee 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.

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 Enrollment Form, claim or as may be otherwise lawfully required, or as I (we) may further authorize.

The Small Group Employee 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.

Employee / Individual or legal representative signature: _____ Date: _____

Name and relationship of legal representative: _____

Last name: _____

First name: _____

Agent / Producer Information	
1. Agent / Agency of Record:	2. Agent / Agency of Record:
Name (print)	Name (print)
Humana Agent #	Humana Agent #
Commission split:	Commission split:
1. Writing Agent / Producer:	2. Writing Agent / Producer:
Name (print)	Name (print)
Humana Agent #	Humana Agent #
Commission split:	Commission split:

As the Writing Agent / Producer, I acknowledge that I am responsible to meet with the primary applicant submitting the Small Group Employee 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 ____/____/____

The original version of this Agreement is in the English language. If there are any discrepancies or conflicts between the English and any other version that has been translated into another language, the English version will control.