

Small Group Employee and Individual Application and 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 and Individual Application and Enrollment Form as "Humana".

- PPO and Indemnity Medical plans insured or administered by Humana Insurance Company.
- Dental plans insured or administered by HumanaDental Insurance Company or Humana Insurance Company.
- Vision plans insured or administered by Humana Dental Insurance Company or Humana Insurance Company.
- Short Term Disability, Long Term Disability 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	

Employee / Individual Information

Hours worked per week: _____ Date of full time hire: ___ / ___ / ___

Social Security Number	Street address	APT / Suite / Box
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City	State	ZIP code	Phone # () _____
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Language: <input type="radio"/> English <input type="radio"/> Spanish <input type="radio"/> Other	E-mail address	Occupation
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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 \$ _____
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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: _____

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 #	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: _____
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Coverage type: Employee / Individual only Employee / Individual and spouse
 Employee / Individual and child(ren) Family
 No Coverage (complete waiver)

Plan name: _____

Health Savings Account	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 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: _____
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Coverage type: Employee / Individual only
 Employee / Individual and spouse
 Employee / Individual and child(ren)
 Family
 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: _____
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Coverage type: Employee / Individual only
 Employee / Individual and spouse
 Employee / Individual and child(ren)
 Family
 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: _____

Short Term Disability	Group #: _____	Benefit #: _____	Class: _____	Div: _____
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Short Term Disability N Y (If no, complete waiver.) Buy-up percent/amount _____

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

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

Accident	Group #: _____	Benefit #: _____	Class: _____	Div: _____
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Accident N Y Benefit Level: 1 2 3 4

Coverage type: Employee / Individual only Employee / Individual and spouse Employee / Individual and child(ren)
 Family

Optional Hospital Intensive Care Unit Benefits Rider
 \$150 \$300 \$450 \$600

Optional Fracture and Dislocation Benefits Rider
 \$750 \$1,500

Optional Accident Total Disability Benefits Rider: Elimination Period: 1 Day 7 Days 14 Days 30 Days
Monthly Benefit: \$400 \$500 \$600 \$700 \$800
 \$900 \$1000

Accident - 2012	Group #: _____	Benefit #: _____	Class: _____	Div: _____
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Accident N Y Benefit Level: 1 2 3 4

Coverage type: Employee / Individual only Employee / Individual and spouse Employee / Individual and child(ren)
 Family

Last name: _____

First name: _____

Disability Income Plus	Group #: _____	Benefit #: _____	Class: _____	Div: _____
<input type="radio"/> Disability Income Covering Accident and Sickness <input type="radio"/> N <input type="radio"/> Y Base Benefit Period: <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 Base Elimination Period: <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				Monthly Benefit \$
<input type="radio"/> Disability Income Covering Accident and Sickness with Waiver of Elimination Period <input type="radio"/> N <input type="radio"/> Y <input type="radio"/> Disability Income Covering Accident and Sickness with Waiver of Elimination Period <input type="radio"/> N <input type="radio"/> Y Base Benefit Period: <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 Base Elimination Period: <input type="radio"/> 0/7 <input type="radio"/> 7/7 <input type="radio"/> 0/14 <input type="radio"/> 14/14				
Optional Disability Income Benefits: <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 \$

Disability Income Advantage	Group #: _____	Benefit #: _____	Class: _____	Div: _____
<input type="radio"/> Disability Income Advantage <input type="radio"/> N <input type="radio"/> Y Base Benefit Period: <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 Base Elimination Period: <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				Monthly Benefit \$
Optional Riders: <input type="radio"/> Hospital Confinement <input type="radio"/> COBRA Rider				
				COBRA Monthly Benefit \$

Critical Illness	Group #: _____	Benefit #: _____	Class: _____	Div: _____
<input type="radio"/> Critical Illness <input type="radio"/> N <input type="radio"/> Y <input type="radio"/> Critical Illness and Cancer <input type="radio"/> N <input type="radio"/> Y		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		
Optional Benefits: <input type="radio"/> Automatic Benefit Increase <input type="radio"/> Health Screening				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? <input type="radio"/> N <input type="radio"/> Y If yes, please indicate whether this applies to you (Employee / Individual), your spouse or a dependent. <input type="radio"/> You (Employee / Individual) <input type="radio"/> Spouse <input type="radio"/> Dependent Name _____				

Group Lump Sum Cancer	Group #: _____	Benefit #: _____	Class: _____	Div: _____
<input type="radio"/> Group Lump Sum Cancer <input type="radio"/> N <input type="radio"/> Y		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		
Does anyone on this application have a parent, brother, or sister with a history of cancer diagnosis prior to age 60? <input type="radio"/> N <input type="radio"/> Y If yes, please indicate whether this applies to you (Employee / Individual), your spouse or a dependent. <input type="radio"/> You (Employee / Individual) <input type="radio"/> Spouse <input type="radio"/> Dependent Name _____				
Rider: <input type="radio"/> Automatic Benefit Increase <input type="radio"/> Health Screenings Base Benefit \$				

Cancer Expense	Group #: _____	Benefit #: _____	Class: _____	Div: _____
<input type="radio"/> Cancer Expense <input type="radio"/> N <input type="radio"/> Y		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"/> Lump Sum Benefit (Equal to 50% of Base Benefit Amount)				Rider: <input type="radio"/> Hospital Indemnity Rider Base Benefit \$

Supplemental Health	Group #: _____	Benefit #: _____	Class: _____	Div: _____
<input type="radio"/> Supplemental Health <input type="radio"/> N <input type="radio"/> Y		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		
Plan type: <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4				

Hospital Indemnity	Group #: _____	Benefit #: _____	Class: _____	Div: _____
<input type="radio"/> Hospital Indemnity <input type="radio"/> N <input type="radio"/> Y		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		
Plan type: <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4				

If your employer or group has elected the critical illness 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 _____

Beneficiary Information for 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) benefits.

1.	Is anyone on this application currently taking any prescribed medication, or do you periodically take medication for a recurrent condition?	<input type="radio"/> N <input type="radio"/> Y
2a.	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	<input type="radio"/> N <input type="radio"/> Y
2b.	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	<input type="radio"/> N <input type="radio"/> Y
3.	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
4.	Within the last 12 months have you or any dependents to be covered been positively diagnosed or treated for: cancer, stroke, diabetes, heart or vascular disease, mental or emotional disorder, muscular or systemic disease (including but not limited to arthritis or lupus), alcohol or drug use, liver, kidney, lung or intestinal disorder, infertility, transplant (recommended, pending or completed), growth disorder, enlarged lymph nodes, or other immune disorders (to include positive diagnosis) for Acquired Immune Deficiency Syndrome (AIDS) or Aids Related Complex (ARC)?	<input type="radio"/> N <input type="radio"/> Y
5.	Within the past 5 years, has anyone on this application been diagnosed with diseases or disorders related to, counseled, consulted, or treated by a doctor, including surgery, for any of the following:	

a.	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	i.	Diabetes; liver or thyroid disease; hepatitis; cirrhosis; or enlargement of the lymph nodes?	<input type="radio"/> N <input type="radio"/> Y
b.	Nervous, mental or emotional disorder; convulsions; epilepsy; unconsciousness; Multiple Sclerosis; Parkinson's Disease; Cerebral Palsy?	<input type="radio"/> N <input type="radio"/> Y	j.	Stomach, gall bladder, digestive, intestinal, or colon disorders?	<input type="radio"/> N <input type="radio"/> Y
c.	Stroke; Transient Ischemic Attack (TIA)?	<input type="radio"/> N <input type="radio"/> Y	k.	Rheumatoid arthritis; or back disorders; or joint disorders?	<input type="radio"/> N <input type="radio"/> Y
d.	Emphysema; asthma, or other disease of lungs, or respiratory organs?	<input type="radio"/> N <input type="radio"/> Y	l.	Paralysis, or any other physical impairment or deformity?	<input type="radio"/> N <input type="radio"/> Y
e.	End stage renal disease; disease of kidney?	<input type="radio"/> N <input type="radio"/> Y	m.	Chronic Fatigue Syndrome/Fibromyalgia?	<input type="radio"/> N <input type="radio"/> Y
f.	Kidney stones; bladder?	<input type="radio"/> N <input type="radio"/> Y	n.	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
g.	Male or female organs; or infertility?	<input type="radio"/> N <input type="radio"/> Y	o.	Alcoholism or drug habit?	<input type="radio"/> N <input type="radio"/> Y
h.	Cancer, and/or cancerous tumor; including skin cancer?	<input type="radio"/> N <input type="radio"/> Y			

6.	Has anyone on this application been advised by a member of the medical profession 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
7.	Within the past 5 years, has anyone on this application seen a health care provider or specialist for a routine physical/wellness exam, or been seen for any reason not previously disclosed?	<input type="radio"/> N <input type="radio"/> Y
8.	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
9.	Hospital Indemnity only: Can you perform your activities of daily living (ADL's) without need of assistance? ADL's include: Bathing, Transferring, Feeding, Dressing and Bowl/Bladder/Toileting.	<input type="radio"/> N <input type="radio"/> Y

Last name:

First name:

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

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 (found at the end of this form), if necessary.

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

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.

<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>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>Waive Coverage for Workplace Voluntary Benefits:</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>Hospital Indemnity 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 Small 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 Small 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.
- In the event that I should decide to apply for coverage hereafter, that subsequent Small 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.
- 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.

Last name: _____

First name: _____

- 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 and Individual Application and 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 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 Small 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 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 and Individual Application and Enrollment Form by Humana.
- Any person who willingly and knowingly submits the Small 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.

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 Disability

If my dependents or I have selected 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.

The Small 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.

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.)

Last name:

First name:

Agent / Producer Information

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

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:

Will the coverage selected replace or change any existing disability insurance policy(s) and/or annuity(s)? NO YES

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

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.