Discrimination is Against the Law

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Humana Inc. and its subsidiaries do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Humana Inc. and its subsidiaries provide:

- Free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.
- Free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as translated documents or oral interpretation.

If you need these services, call 1-877-320-1235 or if you use a TTY, call 711.

If you believe that **Humana Inc. and its subsidiaries** have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Discrimination Grievances
P.O. Box 14618
Lexington, KY 40512 - 4618

If you need help filing a grievance, call 1-877-320-1235 or if you use a TTY, call 711.

You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800–368–1019, 800-537-7697 (TDD)
Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**

Large Group 51+ Employee Enrollment Form — OHIO

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 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.

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in the Large Group 51+ Employee Enrollment Form as "Humana".

- Humana Health Plan of Ohio, Inc., 1100 Employers Blvd, Green Bay, WI 54344
- Humana Insurance Company, 1100 Employers Blvd, Green Bay, WI 54344

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 Indemnity Medical plans, Dental, Life and Vision plans insured or administered by Humana Insurance Company.

Print clearly and completely fill in each applicable circle.

Employer / Group name Employer / Group city State

Qualifying Event Instructions **Office use only**

❍ New business enrollment
❍ New hire/Newly eligible
❍ Dependent birth or adoption
❍ Loss of coverage
❍ Open Enrollment event
❍ Rehire/Reinstatement
❍ Marital status change
❍ Other___________________

Qualifying event date (MM/DD/YYYY) / /

Benefit effective date (MM/DD/YYYY) / /

Employee information

Last name First name MI

Social Security Number - - Date of birth (MM/DD/YYYY) / / Area code ( ) Phone number -

Street address

Apt / Suite / PO box number Gender ❍ Female ❍ Male Language of choice ❍ English ❍ Spanish

City State Zip code County / Parish

E-mail address

Are you actively at work? ❍ Yes ❍ No If not, reason:

❍ Retiree ❍ COBRA Other: ____________________

Date of full-time hire (MM/DD/YYYY) / /

Do you have a disability that affects your ability to communicate or read? ❍ No ❍ Yes

Are you disabled or unable to perform normal work activities? ❍ No ❍ Yes If yes, indicate reason:_____________________________

Annual salary $ Hours worked per week

Occupation

HMO/POS only — Primary care physician name — Primary care physician ID # — Current patient? ❍ Yes ❍ No

HMO/POS only — OB/GYN Primary care physician name (if applicable) — Primary care physician ID # — Current patient? ❍ Yes ❍ No

Dependent information

Enter information for each covered dependent, including spouse.

1 Dependent last name | First name | MI | Gender ❍ Female ❍ Male

Social Security Number ___ - __ - ____ | Date of birth (MM/DD/YYYY) __ / __ / ____ | Relationship ❍ Spouse ❍ Child ❍ Other:______________

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

Not applicable for HumanaAccess HMO

HMO/POS only — Primary care physician name | Primary care physician ID # | Current patient? ❍ Yes ❍ No

HMO/POS only — OB/GYN Primary care physician name (if applicable) | Primary care physician ID # | Current patient? ❍ Yes ❍ No

---

2 Dependent last name | First name | MI | Gender ❍ Female ❍ Male

Social Security Number ___ - __ - ____ | Date of birth (MM/DD/YYYY) __ / __ / ____ | Relationship ❍ Spouse ❍ Child ❍ Other:______________

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

Not applicable for HumanaAccess HMO

HMO/POS only — Primary care physician name | Primary care physician ID # | Current patient? ❍ Yes ❍ No

HMO/POS only — OB/GYN Primary care physician name (if applicable) | Primary care physician ID # | Current patient? ❍ Yes ❍ No

---

3 Dependent last name | First name | MI | Gender ❍ Female ❍ Male

Social Security Number ___ - __ - ____ | Date of birth (MM/DD/YYYY) __ / __ / ____ | Relationship ❍ Spouse ❍ Child ❍ Other:______________

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

Not applicable for HumanaAccess HMO

HMO/POS only — Primary care physician name | Primary care physician ID # | Current patient? ❍ Yes ❍ No

HMO/POS only — OB/GYN Primary care physician name (if applicable) | Primary care physician ID # | Current patient? ❍ Yes ❍ No

---

4 Dependent last name | First name | MI | Gender ❍ Female ❍ Male

Social Security Number ___ - __ - ____ | Date of birth (MM/DD/YYYY) __ / __ / ____ | Relationship ❍ Spouse ❍ Child ❍ Other:______________

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

Not applicable for HumanaAccess HMO

HMO/POS only — Primary care physician name | Primary care physician ID # | Current patient? ❍ Yes ❍ No

HMO/POS only — OB/GYN Primary care physician name (if applicable) | Primary care physician ID # | Current patient? ❍ Yes ❍ No

Use the following alternate address for these dependents: ❍ 1 ❍ 2 ❍ 3 ❍ 4

Street address

Apt / Suite / PO box number

City

State

Zip code

County

Medical

Coverage type:
- ❍ Employee / Individual only
- ❍ Employee / Individual & spouse
- ❍ Employee / Individual & child(ren)
- ❍ Family
- ❍ Other

Office use only

Group #

Benefit #

Class/Div #

Plan name

Network name

Do you or any covered dependent(s) currently have other medical coverage, such as a spouse's plan, another Humana medical plan, or Medicare? ❍ Yes ❍ No If yes, list all: (This section must be completed for Humana to process any medical claims.)

Medicare ID or medical carrier name:

Starting date (MM/DD/YYYY)

/ /

End date, if applicable (MM/DD/YYYY)

/ /

Coverage Type (check all that apply)
- ❍ Employee / Individual
- ❍ Spouse
- ❍ Child(ren)

Medicare ID or medical carrier name:

Starting date (MM/DD/YYYY)

/ /

End date, if applicable (MM/DD/YYYY)

/ /

Coverage Type (check all that apply)
- ❍ Employee / Individual
- ❍ Spouse
- ❍ Child(ren)

Have you or any covered dependent(s) had medical insurance from a company (including another Humana plan) in the past 18 months? ❍ Yes ❍ No If yes, list all: (This section must be completed for Humana to process any medical claims.)

Prior medical carrier name:

Starting date (MM/DD/YYYY)

/ /

End date, if applicable (MM/DD/YYYY)

/ /

Coverage Type (check all that apply)
- ❍ Employee / Individual
- ❍ Spouse
- ❍ Child(ren)

Prior medical carrier name:

Starting date (MM/DD/YYYY)

/ /

End date, if applicable (MM/DD/YYYY)

/ /

Coverage Type (check all that apply)
- ❍ Employee / Individual
- ❍ Spouse
- ❍ Child(ren)

Medical Health History (for 51-100 groups) - Do not submit more than 90 days prior to the effective date

1. Within the past 24 months have you or any dependent to be covered had or been treated for an illness or injury, had surgery or hospitalization recommended? ❍ N ❍ Y
2. Within the past 24 months have you or any dependent to be covered been prescribed medication? ❍ N ❍ Y
3. Have you or any dependent to be covered incurred medical expenses in excess of $7,500 in the past 12 months? ❍ N ❍ Y

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 OH-51340-MH), if necessary.

Question#

Person Treated Last name

First Name

Condition

Treatments received

Medications

Current or future treatments or medications

Date diagnosed (MM/DD/YYYY)

/ /

Date last seen by a doctor (MM/DD/YYYY)

/ /

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.

Office use only
Group # Benefit # Class/Div #

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

Office use only
Group # Benefit # Class/Div #
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

Office use only
Group # Benefit # Class/Div #
FSA DC

Start date (MM/DD/YYYY) ___ / ___ / ___
End date (MM/DD/YYYY) ___ / ___ / ___

Dental

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

Office use only
Group # Benefit # Class/Div #

Plan name

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? ❍ Yes ❍ No
Starting date (MM/DD/YYYY) ___ / ___ / ___
End date, if applicable (MM/DD/YYYY) ___ / ___ / ___

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

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

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

Basic Life / AD&D

Do you elect basic employee / individual life coverage?
❍ Yes ❍ No If no, complete waiver section

Office use only
Group # Benefit # Class/Div #

Class (employer / group will provide you with this information if needed)

Do you elect basic dependent life? ❍ Yes ❍ No If no, complete waiver section

Voluntary Life / AD&D

Do you elect voluntary employee / individual life coverage?
❍ Yes ❍ No If no, complete waiver section
If yes, amount elected (minimum of $15,000):
$, .00

Office use only
Group # Benefit # Class/Div #

Voluntary dependent life selection (available only if employee / individual elects voluntary life coverage):

Do you elect voluntary spouse life coverage? ❍ Yes ❍ No If no, complete waiver section
If yes, voluntary souse life coverage (minimum of $5,000): $, .00
Do you elect voluntary child(ren) life coverage? ❍ Yes ❍ No If no, complete waiver section

Vision

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

Office use only
Group # Benefit # Class/Div #

Plan name

Beneficiary Information for Life

Primary beneficiary
Last name First name MI

Relationship to employee / individual

Secondary beneficiary
Last name First name MI

Relationship to employee / individual

Evidence of Health Status - Do not submit more than 90 days prior to the effective date

Complete this section if you are selecting ONLY Life over the guarantee issue amount.

1.	Is anyone on this application currently taking any prescribed medication, or do you periodically take medication for a recurrent condition?	❍ N ❍ Y

Evidence of Health Status (continued)

Question	Answer
2a. In the past 12 months has any applicant used any tobacco product? If yes, applies to: ❍ You (employee) ❍ Dependent 1 ❍ Dependent 2 ❍ Dependent 3 ❍ Dependent 4	❍ N ❍ Y
2b. Is any applicant currently a smoker? If yes, applies to: ❍ You (employee) ❍ Dependent 1 ❍ Dependent 2 ❍ Dependent 3 ❍ Dependent 4	❍ N ❍ 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?	❍ N ❍ Y
4. Has anyone on this application been diagnosed or received treatment for an immune system disorder (i.e. Lupus, ITP), AIDS or an AIDS-related complex?	❍ N ❍ 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:	

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

Question	Answer
6. **Excluding HIV**, 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?	❍ N ❍ 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?	❍ N ❍ Y

Evidence of Health Status (continued)

	First Name	MI	Height (ft/in)	Weight (lbs)
❍ Employee last name			'	
❍ Dependent 1 last name			'	
❍ Dependent 2 last name			'	
❍ Dependent 3 last name			'	
❍ Dependent 4 last name			'	

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 OH-51340-MH), if necessary.

Question#

Person Treated Last name

First Name

Condition

Treatments received

Medications

Current or future treatments or medications

Date diagnosed (MM/DD/YYYY) / /

Date last seen by a doctor (MM/DD/YYYY) / /

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 below is evidence of this action.

I hereby waive coverage for (check all that apply):

Medical for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Dental for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Basic Life for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Vision for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Health Savings Account for:	❍ Myself		
Flexible Health Account for:	❍ Myself		
Flexible Dependent Care Account for:	❍ Myself		

I decline to apply for group coverage because of:

❍ Spousal coverage
❍ Medicare supplement
❍ Individual coverage
❍ Coverage under another carrier's plan provided by my employer / group
❍ Other:___________________________

True and complete acknowledgment

I understand, agree, and represent:

- I have read the Large Group 51+ 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 Large Group 51+ 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 Large Group 51+ 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. This information will be used only for rating and administrative purposes and not for purposes of eligibility for coverage.

- 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.
- In the event that an application is submitted outside of an open enrollment period, without a qualifying event, or by submitting an incomplete enrollment form Humana reserves the right to delay 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 Large Group 51+ 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 Large Group 51+ Employee Enrollment Form by Humana.

STATE NOTICE:

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.

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). My designated representative or I have the right to receive a copy of this authorization at any time by writing to Humana's Privacy Office.

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 Large Group 51+ Employee 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

If my dependents or I have selected life 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 shall be valid for two years from the date shown below and I have the right to revoke this authorization at any time by writing to Humana's Privacy Office. My designated representative or I have the right to receive a copy of this authorization at any time by writing to Humana's Privacy Office.

The Large Group 51+ 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 any group coverage

Employee / Individual or legal representative signature ______________ Date __ / __ / ____

Name and relationship of legal representative (if a covered dependent) ____

Life Authorization Form

Humana.com

	Group number

Employer name	City	State

Employee name	Date of birth	Social Security Number
Spouse name	Date of birth	Social Security Number

I authorize any physician, medical or health care practitioner, hospital, clinic, veterans administration facility, other medical or medically-related facility, third party administrator, pharmacy, pharmacy benefit manager, insurance, HMO, or reinsuring company, and the Medical Information Bureau, Inc., having information regarding myself, including information concerning, advice, diagnosis, treatment and care of the physical, 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 nonmedical information), and prescription drug history to share any and all such information with Humana, or its reinsurer, or its legal representatives, and its affiliates for purposes of business improvement and development.

I understand and agree:

- Although Humana is required to inform me that any health information obtained will not be redisclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules, any information obtained will not be released by Humana to any person or organization.
- A copy of this authorization is available to me or my legal representative upon written request.
- This authorization shall be valid for two years from the date shown below.
- You have the right to revoke this authorization at any time by sending written notice Humana's Privacy Office. The revocation will become effective after it is received by us but will not apply to information that has already been released in response to this authorization.

Employee signature	Date
Spouse signature	Date