

Humana Employee Enrollment Application

TEXAS

Dental, Life & Short-term Income Protection

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

Life and Short-Term income protection plans insured or administered by Humana Insurance Company. Dental HMO benefits provided by SafeGuard Health Plans, Inc. All other Dental plans insured or administered by HumanaDental Insurance Company or Humana Insurance Company

Please print clearly and fill in each applicable circle.

Dental Group number	Benefit number	Class/Division
Company name	Proposed Effective Date (MMDDYYYY)	
Company city	State	

Employee Information

Last name	First name	MI	Date of birth
Social Security number	Phone number		
Gender: <input type="radio"/> Female <input type="radio"/> Male	Email address		
Street address	Apt / Suite / PO Box number		
City	State	Zip code	County
Language of choice: <input type="radio"/> English <input type="radio"/> Spanish			
Employment status: <input type="radio"/> Full-time employee: Number of hours worked per week	Date of full-time hire	<input type="radio"/> Retiree	
Are you disabled or unable to perform normal activities? <input type="radio"/> No <input type="radio"/> Yes If yes, indicate reason:			
Do you have a disability that affects your ability to communicate or read? <input type="radio"/> No <input type="radio"/> Yes			

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Dependent Information

Please enter information for each dependent, including spouse, applying for coverage. For additional dependents, copy and attach an additional Dependent Information form.

1. Last name	First name	MI	Date of birth
Social Security number	Gender: <input type="radio"/> Female <input type="radio"/> Male	Relationship: <input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other:	
Dependent status (if applicable): <input type="radio"/> Full-time student <input type="radio"/> Disabled	If disabled, indicate reason:		
DHMO: Primary dentist	Facility number	Current Patient: <input type="radio"/> No <input type="radio"/> Yes	

2. Last name	First name	MI	Date of birth
Social Security number	Gender: <input type="radio"/> Female <input type="radio"/> Male	Relationship: <input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other:	
Dependent status (if applicable): <input type="radio"/> Full-time student <input type="radio"/> Disabled	If disabled, indicate reason:		
DHMO: Primary dentist	Facility number	Current Patient: <input type="radio"/> No <input type="radio"/> Yes	

3. Last name	First name	MI	Date of birth
Social Security number	Gender: <input type="radio"/> Female <input type="radio"/> Male	Relationship: <input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other:	
Dependent status (if applicable): <input type="radio"/> Full-time student <input type="radio"/> Disabled	If disabled, indicate reason:		
DHMO: Primary dentist	Facility number	Current Patient: <input type="radio"/> No <input type="radio"/> Yes	

4. Last name	First name	MI	Date of birth
Social Security number	Gender: <input type="radio"/> Female <input type="radio"/> Male	Relationship: <input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other:	
Dependent status (if applicable): <input type="radio"/> Full-time student <input type="radio"/> Disabled	If disabled, indicate reason:		
DHMO: Primary dentist	Facility number	Current Patient: <input type="radio"/> No <input type="radio"/> Yes	

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Group Number

Social Security Number

Dental

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

DHMO: Primary dentist Facility number Current Patient: No Yes

Plan name

Within the past 12 months, have you had any individual or other group dental coverage? No Yes Orthodontia coverage? No Yes

Effective date Term date

Prior coverage type: Employee only Employee and spouse Employee and child(ren) Family

TX-80124-HD 1/2006

Basic Life

Group number Benefit number Class/Division

Primary beneficiary name Secondary beneficiary name

Class (employer will provide you with this information if needed) Annual salary (if applicable) \$

Basic dependent life: No Yes If no, complete waiver section.

Voluntary Life

Group number Benefit number Class/Division

Do you elect voluntary employee life coverage? No Yes Amount (minimum of \$15,000) \$ Annual salary \$

Primary beneficiary name Secondary beneficiary name

Voluntary dependent life: (available only if employee elects voluntary life coverage) Do you elect voluntary child(ren) life coverage? No Yes

Do you elect voluntary spouse life coverage? No Yes Amount (minimum of \$5,000) \$

TX-80124-HL 1/2006

Short-term Income Protection

Group number Benefit number Class/Division

Do you elect short-term income protection coverage? No Yes Annual salary \$

Class (employer will provide if needed)

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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. I proclaim that I was not pressured or forced by my employer, 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):

Dental for: Myself My spouse My dependent child(ren)

Basic life for: Myself My spouse My dependent child(ren)

Short-term income protection for: Myself

I decline to apply for group coverage because of (check all that apply): Spousal coverage Medicare supplement Individual coverage Coverage under another carrier's plan provided by my employer Other:

I understand and agree:

- In the event that I should decide to apply for such coverage hereafter, that such subsequent application shall be subject to the applicable terms and conditions of the master group contract(s) or plan provisions as described in the Summary Plan Description which may require additional limitations and waiting periods.
- In the event that I should decide to apply for HMO or POS coverage hereafter, I will only be eligible at the group's open enrollment period.
- In the event that I should decide to apply for PPO, Classic and Indemnity coverage hereafter, Humana reserves the right to impose a 12-month pre-existing limitation.
- I may be required to furnish, at my own expense, evidence of health status satisfactory to Humana.
- 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 I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents provided that I request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.
- Humana reserves the right to delay medical coverage and/or deny life or dental coverage with any future application for coverage.

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Agreement

True and complete acknowledgement

I understand, agree and represent:

- I have read this document or it has been read to me.
- The answers provided within this entire application for coverage are to the best of my knowledge and belief, true and complete.
- Neither my employer nor the agent has the authority to waive a complete answer to any question, determine coverage or insurability, alter any contract, or waive any of Humana’s other rights and requirements.
- If this application for coverage is accepted, coverage will be effective on the date specified by Humana on the certificate of coverage/certificate of insurance.
- Any intentional material false statement, misrepresentation or omission contained herein relied on by Humana may be used to reduce or deny a claim or void the contract within the contestable period if such intentional misrepresentation or omission materially affected the acceptance of the risk.
- For small employer groups, I understand that any misstatements of health status will not be used to cancel, non-renew or void my medical coverage under this policy or plan but may result in an increase in medical premiums following a written notice as required in the Policy or Group Contract.

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

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

Authorization

My dependents and I authorize any physician, medical or health care practitioner, hospital, clinic, veterans administration facility, other medical or medically-related facility, third party administrator, Pharmacy Benefit Manager, insurance, HMO or reinsuring company, the Medical Information Bureau, Inc., employer, the Consumer Reporting Agency or banking and financial institutions having information regarding myself and my dependents, including information concerning, advice, diagnosis, treatment and care of the physical, psychiatric, mental or emotional conditions, drug, substance or alcohol abuse, illness, and copies of all hospital or medical records, non-public personal health information, and any other non-medical information to share any and all such information with Humana, its reinsurer or its legal representatives, and its affiliates.

My dependents and I understand and agree:

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

Signature - please sign below if enrolling or waiving group coverage

Employee or legal representative signature: _____ Date: _____

Name and relationship of legal representative: _____

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**Humana Insurance Company
HumanaDental Insurance Company
SafeGuard Health Plans, Inc.**