Large Group 51+ Employee Enrollment Form — FLORIDA

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

PPO, EPO and Indemnity plans insured by ❍ Humana Health Insurance Company of Florida, Inc. POS, HMO and National POS plans offered by ❍ Humana Medical Plan, Inc. Prepaid plans offered and administered by ❍ CompBenefits Company. All other Dental plans, Vision and Life plans insured or administered by ❍ Humana Insurance Company.

Print clearly and completely fill in each applicable circle.

Employer / Group name: Right Way Plumbing
Employer / Group city: sunrise
State: FL

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 / Individual 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

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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

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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

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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

Do you wish to extend coverage for your dependent adult child(ren) up to age 30? ❍ No ❍ Yes

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 1-18 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) *Late Enrollee Only* - Do not submit more than 90 days prior to the effective date

1. To the best of your knowledge, within the past 24 months have you or any dependent to be covered had or been treated by a licensed medical professional, for an illness or injury, had surgery or hospitalization recommended? ❍ N ❍ Y
2. To the best of your knowledge, within the past 24 months have you or any dependent to be covered been prescribed medication by a licensed medical professional? ❍ N ❍ Y
3. To the best of your knowledge, 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 UT-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?	Starting date (MM/DD/YYYY)	End date, if applicable (MM/DD/YYYY)
	❍ Yes ❍ No	/ /	/ /

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

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

Coverage type check all that apply)
❍ Employee / Individual only
❍ Employee / Individual and spouse
❍ Employee / Individual and child(ren)
❍ 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 to the best of your knowledge, if you are selecting **Life benefits or are a late enrollee**.

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

Evidence of Health Status (continued)

Question	Answer
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 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?	❍ N ❍ Y

5. 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:

	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 condition; 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 conditions?	❍ N ❍ Y
k.	Rheumatoid arthritis; or back conditions; or joint conditions?	❍ 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. 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?	❍ N ❍ Y
7. Within the past 5 years, has anyone on this application been seen by a licensed medical provider or specialist for a routine physical/wellness exam, or been seen for any reason not previously disclosed?	❍ N ❍ Y

	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			'	

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 Scheduled treatments or medications

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

Waiver (refusal of coverage)

I hereby waive coverage for (check all that apply):				I decline to apply for group coverage because of:
Medical for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)	❍ Spousal coverage
Dental for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)	❍ Medicare supplement
Basic Life for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)	❍ Individual coverage
Vision for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)	❍ Coverage under another carrier's plan provided by my employer / group
Health Savings Account for:	❍ Myself			❍ Other:________________________
Flexible Health Account for:	❍ Myself			
Flexible Dependent Care Account for:	❍ Myself			

True and complete acknowledgment

I understand, agree, and represent:

- I have read the Large 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 Large 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 Large 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.
- 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.
- 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 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 Employee Enrollment Form by Humana.
- Any person who willingly and knowingly submits the Large 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 Large Group 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 is valid for 24 months and can be revoked at any time. The signature is true and accurate and a copy of the signature is valid as the original.

The Large 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 any group coverage

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 ____
(if a covered dependent)

Agent / Producer Information

1. Agent / Agency of Record:	2. Agent / Agency of Record:
Name (print)	Name (print)
Humana Agent #	Humana Agent #
Florida License ID #	Florida License ID #
Commission split:	Commission split:
1. Writing Agent / Producer:	**2. Writing Agent / Producer:**
Name (print)	Name (print)
Humana Agent #	Humana Agent #
Florida License ID #	Florida License ID #
Commission split:	Commission split:

Agent replacement question:

Will the coverage selected replace or change any existing life 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 Large 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 __ __/__ __/__ __ __ __

Important!

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, marital status, or religion. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws.
If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:
  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 their Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019**, **800-537-7697 (TDD)**. Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.
- **California residents**: You may also call California Department of Insurance toll-free hotline number: **1-800-927-HELP (4357)**, to file a grievance.

Auxiliary aids and services, free of charge, are available to you. 1-877-320-1235 (TTY: 711)

Humana provides 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.

Language assistance services, free of charge, are available to you. 1-877-320-1235 (TTY: 711)

Español (Spanish): Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.
繁體中文 (Chinese): 撥打上面的電話號碼即可獲得免費語言援助服務。
Tiếng Việt (Vietnamese): Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.
한국어 (Korean): 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오 .
Tagalog (Tagalog – Filipino): Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.
Русский (Russian): Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.
Kreyòl Ayisyen (French Creole): Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.
Français (French): Appelez le numéro ci-dessus pour recevoir gratuitement des services d’aide linguistique.
Polski (Polish): Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.
Português (Portuguese): Ligue para o número acima indicado para receber serviços linguísticos, grátis.
Italiano (Italian): Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.
Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.
日本語 **(Japanese)**: 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。

فارسی (Farsi) برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.

Diné Bizaad (Navajo): Wódahí béésh bee hani’í bee wolta’ígíí bich’į’ hódíílnih éí bee t’áá jiik’eh saad bee áká’ánída’áwo’dę́ę́ niká’adoowoł.

العربية (Arabic) الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

GCHJV5REN 0220