Division of Insurance

COLORADO UNIFORM EMPLOYEE APPLICATION FOR SMALL GROUP HEALTH BENEFIT PLANS

This form is designed for an employee's initial application for coverage. Please contact your agent or the carrier to determine if this form should be used in other situations once the group is enrolled with the carrier.

COVERAGE INFORMATION

Application Type:	☐ New Coverage	☐ Change/Modification to Existing Policy	☐ Open Enrollment	☐ Special Enrollment*

* Proof of eligibility for special enrollment will be required – information on eligibility for special enrollment periods is available at: www.dora.colorado.gov/DOI/HealthApp

EMPLOYER INFORMATION

Employee Name:		**Employer Name:**	
Proposed Effective Date:		**Group Number (if known):**	

EMPLOYEE INFORMATION

Employee Instructions: Please type or print using black or blue ink. Please fill out the entire application for each person for whom coverage is being sought.

First Name:		Middle Initial:		Last Name:	
Social Security #:		Date of Birth:		Current Age:	Sex: ☐ M ☐ F
Address:				City:	
County:		State:		Zip:	
Mailing Address (If different):				City:	
County:		State:		Zip:	
Home Phone:		Email:		☐ Home	☐ Work
What is your job title at your current employer?				Work Phone:	
What was your first day of employment?		How many hours, on average, do you work each week?			

Are you (check one):	☐ Single	☐ Married	☐ Common Law*	☐ Civil Union*
	☐ Designated Beneficiary*	☐ Legally Separated	☐ Divorced	☐ Widow or Widower

* A common law, civil union, or designated beneficiary certification may be required by the carrier

Are you on COBRA or State Continuation?	☐ Yes	☐ No	Start Date:		Stop Date:	

TYPE OF HEALTH COVERAGE

List all dependents (spouse/partner and child(ren)) applying for coverage. **If you need additional space, please use a separate sheet of paper and attach it to this application (please print your name and sign and date the additional sheet).**

Please select the type of health insurance coverage for which you are applying: ☐ Employee Only ☐ Employee & Family

DEPENDENT INFORMATION
(list all dependents to be covered)

Name (First, MI, Last)	Sex	Social Security Number	Relationship	Disabled	Birth Date (MM/DD/YY)
	☐ M ☐ F		SPOUSE/PARTNER		
	☐ M ☐ F		☐ CHILD ☐ STEPCHILD	☐ Yes ☐ No	
	☐ M ☐ F		☐ CHILD ☐ STEPCHILD	☐ Yes ☐ No	
	☐ M ☐ F		☐ CHILD ☐ STEPCHILD	☐ Yes ☐ No	

Employee Name: ______________________________ SSN: ________________________________

Name	Sex	Social Security Number	Relationship	Disabled	Birth Date
	☐ M ☐ F		☐ CHILD ☐ STEPCHILD	☐ Yes ☐ No	
	☐ M ☐ F		☐ CHILD ☐ STEPCHILD	☐ Yes ☐ No	
	☐ M ☐ F		☐ CHILD ☐ STEPCHILD	☐ Yes ☐ No	
	☐ M ☐ F		☐ CHILD ☐ STEPCHILD	☐ Yes ☐ No	
	☐ M ☐ F		☐ CHILD ☐ STEPCHILD	☐ Yes ☐ No	
	☐ M ☐ F		☐ CHILD ☐ STEPCHILD	☐ Yes ☐ No	
	☐ M ☐ F		☐ CHILD ☐ STEPCHILD	☐ Yes ☐ No	
	☐ M ☐ F		☐ CHILD ☐ STEPCHILD	☐ Yes ☐ No	
	☐ M ☐ F		☐ CHILD ☐ STEPCHILD	☐ Yes ☐ No	
	☐ M ☐ F		☐ CHILD ☐ STEPCHILD	☐ Yes ☐ No	
	☐ M ☐ F		☐ CHILD ☐ STEPCHILD	☐ Yes ☐ No	
	☐ M ☐ F		☐ CHILD ☐ STEPCHILD	☐ Yes ☐ No	
	☐ M ☐ F		☐ CHILD ☐ STEPCHILD	☐ Yes ☐ No	
	☐ M ☐ F		☐ CHILD ☐ STEPCHILD	☐ Yes ☐ No	
	☐ M ☐ F		☐ CHILD ☐ STEPCHILD	☐ Yes ☐ No	
	☐ M ☐ F		☐ CHILD ☐ STEPCHILD	☐ Yes ☐ No	
	☐ M ☐ F		☐ CHILD ☐ STEPCHILD	☐ Yes ☐ No	

Employee Name:	Employer Name:

TOBACCO USE

Please answer the following questions to the best of your knowledge. 45 CFR 147.102(a)(1)(iv) "For purposes of this section, tobacco use means use of tobacco on average four or more times per week within no longer than the past 6 months. This includes all tobacco products, except that tobacco use does not include religious or ceremonial use of tobacco. Further, tobacco use must be defined in terms of when a tobacco product was last used."

Has anyone named in this application used tobacco or smokeless tobacco during the past 6 months? If yes, provide the information requested below.

Name of Person	Used Tobacco Products	If Yes, check all that apply	Duration	Frequency
	☐ Yes	☐ Cigarettes		
	☐ No	☐ Pipe/Cigars		

If Tobacco Use Information Has Been Entered It Will Appear on the Following Page(s)

EMPLOYEE/DEPENDENT WAIVER OF COVERAGE

Complete this section ONLY if you are not enrolling yourself or your spouse/partner or dependents. Waiver must be completed for all of your dependents to be eligible for enrollment on this plan in the event of changing circumstances. I understand that I am eligible to apply for group health coverage through my employer. I do **NOT** want, and hereby waive, group health coverage for:

	Name (Last, First, MI)	Birth Date (Mo/Day/Year)
Employee		
Spouse/Partner		
Dependent 1		
Dependent 2		
Dependent 3		

If Waiving Coverage, Information Will Appear on the Following Page(s)

I am **waiving** group health coverage for myself and/or the dependents listed above because (check all that apply, **copy of ID card may be required**):

If Waiving Coverage, Information Will Appear on the Following Page(s)

WAIVER: I certify that I have been given the opportunity to apply for group health coverage and decline to enroll as indicated above, on behalf of myself, my spouse/partner and my dependent child(ren). I understand that by signing this waiver, I, my spouse/partner, and my dependent child(ren) forfeit the right to coverage. I was not pressured, forced or unfairly induced by my employer, the agent or the carrier(s) into waiving or declining the group health coverage. If in the future I apply for coverage, I, my spouse/partner, or any of my dependent child(ren) may be treated as a late enrollee and subject to postponement of coverage for up to 12 months.

I understand that if I am declining enrollment for myself, my spouse/partner, or my dependent child(ren) because of other health coverage, I may, in the future, be able to enroll myself, my spouse/partner, or my dependent child(ren) in this plan, as required by law, provided that I request enrollment within 30 days after my other health coverage ends or a qualifying event occurs. **If I do not request enrollment within 30 days of the above events, I understand that I may not be able to enroll for coverage until my company's Open Enrollment period. I understand that I can obtain information related to my enrollment eligibility from my employer or small group health carrier.**

Signature of Employee: **Date Signed:**

Employee Name:	Employer Name:

MEDICARE INFORMATION

If you need to complete this section for more than one person, please use a separate sheet of paper and attach it to this application (please sign and date the additional sheet). A copy of your ID card may be required.

If Medicare Coverage Has Been Entered It Will Appear on the Following Page(s)

CURRENT MEDICAL COVERAGE

Do you, your spouse/partner, or your dependent child(ren) listed in this application currently have health insurance coverage? ☐ Yes ☐ No

Is the plan information listed below the same for your spouse/partner and all dependents? If yes, skip to next section. ☐ Yes ☐ No

Your information will help the small employer carrier(s) to coordinate benefits with any other group health coverage you may have.

Name	Carrier Name Carrier Phone Number	Plan Name Group Number Subscriber ID#	Effective Date of Coverage (MM/DD/YY)	Termination Date of Coverage (MM/DD/YY)	Type of Coverage (See Key Below)

If Other Medical Coverage Has Been Entered It Will Appear on the Following Page(s)

Type of Coverage Key: **G** = Group Comprehensive Major Medical; **I** = Individual Comprehensive Major Medical; **MS** = Medicare Supplement; **H** = Hospital Coverage Only; **V** = Vision Coverage Only **O**=Other, please explain:_____

HEALTH PROVIDER OR PRODUCT SELECTION, IF APPLICABLE

Please select the type of coverage for which you are applying from the plans offered by your employer and issued by the carrier. This section should be completed only if the small employer group insurance for which you are applying requires the selection of a primary care provider. A selection should be made for each individual applying for such coverage and for each carrier from which insurance coverage is being sought. The provider information may be listed in the provider materials that are supplied by each carrier to your employer. Use additional sheets if necessary.

Covered Person's Name	Medical Plan	Primary Care Physician Name:	Primary Care Physician Address: (optional)	Is this your current provider?

Employee Name:	Employer Name:

TERMS AND CONDITIONS

I acknowledge that I have read all sections of this Colorado Uniform Employee Application for Small Employer Group Health Coverage (Application), and I certify on behalf of my eligible family dependents and myself that the answers contained in this Application are complete and accurate to the best of my knowledge. I understand and agree that neither my employer nor any insurance agents have any authority to waive my complete answer to any question, agree to insurability, alter any contract, or waive any Colorado small employer carrier's other rights or requirements.

I hereby apply for enrollment for myself and for my eligible family dependents listed. On behalf of my eligible family dependents and myself, I agree to all of the terms and conditions of the group contract(s) with Colorado small employer carrier(s) under which I wish to enroll for coverage. I have indicated in this Application, if required, what product(s) or provider(s) I have selected. **I agree that no coverage will be effective until the date specified by the Colorado small employer carrier(s) with whom I enroll, after this application has been accepted by such carrier(s)**.

I understand and agree that any information obtained in connection with this Application will be used by Colorado small employer carrier(s) to determine eligibility for coverage.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance carrier for the purpose of defrauding or attempting to defraud the carrier. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance carrier or agent of an insurance carrier who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

When applicable, I authorize my employer to deduct contributions from my earnings to be applied to the cost of coverage.

I agree to any applicable group contract provisions for the resolution of disagreements and disputes, including arbitration when required and as allowed by law. Please refer to any arbitration provisions in the group contract(s).

I understand that I may request a copy of this Application. I agree that a photographic copy of this Application shall be as valid as the original. A legible facsimile signature shall have the same force and effectiveness as the original. This document will become a part of the contract when coverage is approved and issued.

Signature of Employee: _____ **Date Signed:** _____

DISCLOSURES

COLORADO INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY APPLICABLE HEALTH BENEFIT PLAN IT MARKETS IN COLORADO TO ANY SMALL EMPLOYER THAT APPLIES FOR THE PLAN AND AGREES TO MAKE THE REQUIRED PREMIUM PAYMENTS, AND SATISFIES THE OTHER PROVISIONS OF THE HEALTH BENEFIT PLAN.

This document is a publication of the Colorado Division of Insurance. If you have questions about the content of this document please contact our offices at 303-894-7499 or visit our website at http://dora.colorado.gov/insurance. For questions regarding coverage or enrollment please see your employer.

Employee Name:	Employer Name:

This page may be used to provide additional information that was required in the sections above and did not fit in the space provided.

If Additional Information Has Been Entered It Will Appear on the Previous Page(s)

Signature of Employee: _____ Date Signed: _____

Group Employee and Individual Application and Enrollment Form - 1-50 Employees Colorado

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". To elect primary care physician or dentist, please complete reorder CO-51340-PP.

Medical and Life plans insured or administered by Humana Insurance Company. HMO plans offered or administered by Humana Health Plan, Inc. and insured or administered by Humana Insurance Company. Dental plans insured or administered by HumanaDental Insurance Company or Humana Insurance Company. Alpha Dental Plan insured and administered by Beta Health Association, Inc. Vision plans insured or administered by CompBenefits Insurance Company or HumanaDental Insurance Company or Humana Insurance Company. Short Term Disability, Long Term Disability, Life and Workplace Voluntary plans insured by Kanawha Insurance Company.

Please print clearly and fill in each applicable circle.

Proposed effective date:

Employer / Group name	Employer / Group city	State

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		❍ F ❍ M		❍ Y ❍ N	N/A (complete in Employee/ Individual Information section.)
Spouse* / Domestic Partner		❍ F ❍ M		❍ Y ❍ N	
Child / Dependent		❍ F ❍ M		❍ Y ❍ N	
Child / Dependent		❍ F ❍ M		❍ Y ❍ N	
Child / Dependent		❍ F ❍ M		❍ Y ❍ N	
Other (specify):		❍ F ❍ M		❍ Y ❍ N	

*Spouse also includes partner of a civil union

Employee / Individual Information

Hours worked per week: **Date of full time hire:**

Social Security Number	Street address	APT / Suite / Box

City	State	ZIP code	Phone #

Language: ❍ English ❍ Spanish ❍ Other	E-mail address	Occupation

Employment status (check one) ❍ Active ❍ Retiree ❍ COBRA	Annual salary $

Prior / Existing Coverage: IMPORTANT - DO NOT cancel any existing coverage until you receive written notification from Humana of your acceptance for coverage.

Medical

1. Prior medical coverage during the past 18 months (individual or other group coverage)? ❍ N ❍ Y

Prior medical insurance carrier name	Policy #	**Prior coverage type:** ❍ Employee / Individual only ❍ Employee / Individual and spouse* ❍ Employee / Individual and child(ren) ❍ 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:** ❍ Employee / Individual only ❍ Employee / Individual and spouse* ❍ Employee / Individual and child(ren) ❍ Family	Effective date / Term date

3. Medicare

Employee / Individual coverage: ❍ N ❍ Y	Medicare ID	Effective date[A:] [B:]	Term date
Spouse* coverage: ❍ N ❍ Y	Medicare ID	Effective date[A:] [B:]	Term date

*Spouse also includes partner of a civil union

Last name:	First name:

STATE NOTICE

COLORADO INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY HEALTH BENEFIT PLAN IT MARKETS IN COLORADO TO SMALL EMPLOYERS OF 1-50 EMPLOYEES, UPON THE REQUEST OF A SMALL EMPLOYER TO THE ENTIRE SMALL GROUP REGARDLESS OF THE HEALTH STATUS OF ANY INDIVIDUALS IN THE GROUP.

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:** ❍ Employee / Individual only ❍ Employee / Individual and spouse* ❍ Employee / Individual and child(ren) ❍ Family
	Effective date	
Prior carrier phone #	Term date	

Coverage Options

Medical

Group #: | Benefit #: | Class/Div:

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:

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 employee / individual's estate. You may change beneficiary information on file with the bank that administers the HSA once the account is established.

If selecting the Health Savings Account (HSA), I authorize Humana or its banking partners to provide my account number to my employer for the purposes of depositing any contributions.

Dental

Group #: | Benefit #: | Class/Div:

Coverage type:
- ❍ Employee / Individual only — Rate Amount $_____ Rate Frequency (Monthly)
- ❍ Employee / Individual and spouse* — Rate Amount $_____ Rate Frequency (Monthly)
- ❍ Employee / Individual and child(ren) — Rate Amount $_____ Rate Frequency (Monthly)
- ❍ Family — Rate Amount $_____ Rate Frequency (Monthly)
- ❍ No Coverage (complete waiver)

Plan name:

Basic Life / AD&D

Group #: | Benefit #: | Class/Div:

Basic dependent life ❍ N ❍ Y (If no, complete waiver.) | Class (employer will provide you with this information, if needed)

Voluntary Life / AD&D

Group #: | Benefit #: | Class/Div:

Voluntary employee / individual life coverage ❍ N ❍ Y | Amount (min $15,000) $

Voluntary spouse* life coverage? ❍ N ❍ Y | Amount (min $5,000) $ | **Voluntary child(ren) life coverage?** ❍ N ❍ Y

Vision

Group #: | Benefit #: | Class/Div:

Coverage type:
- ❍ Employee / Individual only — Rate Amount $_____ Rate Frequency (Monthly)
- ❍ Employee / Individual and spouse* — Rate Amount $_____ Rate Frequency (Monthly)
- ❍ Employee / Individual and child(ren) — Rate Amount $_____ Rate Frequency (Monthly)
- ❍ Family — Rate Amount $_____ Rate Frequency (Monthly)
- ❍ No Coverage (complete waiver)

Plan name:

Short Term Disability

Group #: | Benefit #: | Class: | Div:

Short Term Disability ❍ N ❍ Y (If no, complete waiver.) Buy-up percent/amount _____

Long Term Disability

Group #: | Benefit #: | Class: | Div:

Long Term Disability ❍ N ❍ Y (If no, complete waiver.) Buy-up percent/amount _____

*Spouse also includes partner of a civil union

Last name: | First name:

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

Accident Group #: | Benefit #: | Class: | Div:

❍ 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
Elimination Benefit: ❍ $400 ❍ $500 ❍ $600 ❍ $700 ❍ $800 ❍ $900 ❍ $1000

Accident - 2012 Group #: | Benefit #: | Class: | Div:

❍ Accident ❍ N ❍ Y — Benefit Level: ❍ 1 ❍ 2 ❍ 3 ❍ 4

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

Disability Income Plus Group #: | Benefit #: | Class: | Div:

❍ Disability Income Covering Accident and Sickness ❍ N ❍ Y
Base Benefit Period: ❍ 3 Month ❍ 6 Month ❍ 1 Year ❍ 2 Year ❍ 3 Year
Base Elimination Period: ❍ 0/7 ❍ 7/7 ❍ 0/14 ❍ 14/14 ❍ 30/30 ❍ 60/60 ❍ 90/90 ❍ 180/180 ❍ 365/365

Monthly Benefit $

❍ Disability Income Covering Accident and Sickness with Waiver of Elimination Period ❍ N ❍ Y
Base Benefit Period: ❍ 3 Month ❍ 6 Month ❍ 1 Year ❍ 2 Year ❍ 3 Year
Base Elimination Period: ❍ 0/7 ❍ 7/7 ❍ 0/14 ❍ 14/14

Optional Disability Income Benefits: ❍ ICU / CCU Benefit ❍ $200 ❍ $400 ❍ $600 ❍ $800
❍ Physical Therapy Benefit ❍ COBRA Rider — COBRA Monthly Benefit $

Disability Income Advantage Group #: | Benefit #: | Class: | Div:

❍ Disability Income Advantage ❍ N ❍ Y
Base Benefit Period: ❍ 3 Month ❍ 6 Month ❍ 1 Year ❍ 2 Year ❍ 3 Year
Base Elimination Period: ❍ 0/7 ❍ 7/7 ❍ 0/14 ❍ 14/14 ❍ 30/30 ❍ 60/60 ❍ 90/90 ❍ 180/180 ❍ 365/365

Monthly Benefit $

Optional Riders: ❍ Hospital Confinement ❍ COBRA Rider — COBRA Monthly Benefit $

Whole Life / AD&D Group #: | Benefit #: | Class: | Div:

❍ Whole Life / AD&D ❍ N ❍ Y | ❍ Whole Life 99 | ❍ Whole Life 65 | Employee / Individual Benefit $

❍ AD&D Rider ❍ Automatic Premium Loan Option

❍ Automatic Benefit Increase Rider ❍ $1 / Week ❍ $2 / Week

❍ Employee / Individual Term Rider to 65 Employee / Individual Benefit $

❍ Family Term Rider Spouse* Benefit $ Child(ren) Benefit $

Whole Life Spouse / AD&D Group #: | Benefit #: | Class: | Div:

❍ Stand Alone Spouse* / AD&D ❍ N ❍ Y | ❍ Whole Life 99 | ❍ Whole Life 65 | Spouse* Benefit $

❍ AD&D Rider | ❍ Family Term Rider (Child Coverage Only) Child(ren) Benefit Amount $ | ❍ Automatic Premium Loan Option

*Spouse also includes partner of a civil union

Last name:	First name:

Whole Life Child(ren) / AD&D Group #:		Benefit #:		Class:		Div:	

❍ Whole Life Child(ren) / AD&D ❍ N ❍ Y

Child(ren) listed here must also be included as dependents under the Enrollment Information section of this application.

❍ N ❍ Y **Coverage on Child 1**	Child 1 Name	Child 1 Benefit $
❍ N ❍ Y **Coverage on Child 2**	Child 2 Name	Child 2 Benefit $
❍ N ❍ Y **Coverage on Child 3**	Child 3 Name	Child 3 Benefit $

Level Term Life Group #:		Benefit #:		Class:		Div:	

❍ Level Term Life / AD&D ❍ N ❍ Y	**Coverage type:** ❍ Employee / Individual only ❍ Spouse* ❍ Child(ren)	**Base Plan:** ❍ 10-Year Term ❍ 20-Year Term **Optional Benefit:** ❍ Automatic Benefit Increase
Employee / Individual Benefit $	Spouse* Benefit $	Child(ren) Benefit $

If your employer or group has elected the critical illness rider, have you or any dependent had 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_____

Critical Illness Group #:		Benefit #:		Class:		Div:	

❍ Critical Illness ❍ N ❍ Y ❍ Critical Illness and Cancer ❍ N ❍ Y	**Coverage type:** ❍ Employee / Individual only ❍ Employee / Individual and spouse* ❍ Employee / Individual and child(ren) ❍ Family
Optional Benefits: ❍ Automatic Benefit Increase ❍ Health Screening ❍ Return on Premium	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? ❍ N ❍ Y If yes, please indicate whether this applies to you (Employee / Individual), your spouse* or a dependent.
❍ You (Employee / Individual) ❍ Spouse* ❍ Dependent Name_____

Group Lump Sum Cancer Group #:		Benefit #:		Class:		Div:	

❍ Group Lump Sum Cancer ❍ N ❍ Y	**Coverage type:** ❍ Employee / Individual only ❍ Employee / Individual and spouse* ❍ Employee / Individual and child(ren) ❍ Family

Does anyone on this application have a parent, brother, or sister with a history of 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_____

Rider: ❍ Automatic Benefit Increase ❍ Health Screenings	Base Benefit $

Cancer Expense Group #:		Benefit #:		Class:		Div:	

❍ Cancer Expense ❍ N ❍ Y	**Coverage type:** ❍ Employee / Individual only ❍ Employee / Individual and spouse* ❍ Employee / Individual and child(ren) ❍ Family	
❍ Lump Sum Benefit (Equal to 50% of Base Benefit Amount)	**Rider:** ❍ Hospital Indemnity Rider	Base Benefit $

Supplemental Health Group #:		Benefit #:		Class:		Div:	

❍ Supplemental Health ❍ N ❍ Y	**Coverage type:** ❍ Employee / Individual only ❍ Employee / Individual and spouse* ❍ Employee / Individual and child(ren) ❍ Family
Plan type: ❍ 1 ❍ 2 ❍ 3 ❍ 4	

Beneficiary Information for Life, 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

*Spouse also includes partner of a civil union

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.

1a.	In the past 12 months has any applicant used any tobacco product? If yes, applies to: ❍ Employee ❍ Spouse*/Domestic Partner ❍ Other ❍ Child/Dependent names_____	❍ N ❍ Y
1b.	Is any applicant currently a smoker? If yes, applies to: ❍ Employee ❍ Spouse*/Domestic Partner ❍ Other ❍ Child/Dependent names_____	❍ N ❍ Y
2.	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
3.	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
4.	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)?	❍ N ❍ Y	**g.**	Diabetes; liver or thyroid disease; hepatitis; cirrhosis; or enlargement of the lymph nodes?	❍ N ❍ Y
b.	Nervous, mental or emotional disorder; convulsions; epilepsy; unconsciousness; Multiple Sclerosis; Parkinson's Disease; Cerebral Palsy?	❍ N ❍ Y	**h.**	Rheumatoid arthritis; or back disorders; or joint disorders?	❍ N ❍ Y
c.	Stroke; Transient Ischemic Attack (TIA)?	❍ N ❍ Y	**i.**	Paralysis, or any other physical impairment or deformity?	❍ N ❍ Y
d.	Emphysema; asthma, or other disease of lungs, or respiratory organs?	❍ N ❍ Y	**j.**	Chronic Fatigue Syndrome/Fibromyalgia?	❍ N ❍ Y
e.	End stage renal disease; disease of kidney?	❍ N ❍ Y	**k.**	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
f.	Cancer, and/or cancerous tumor; including skin cancer?	❍ N ❍ Y	**l.**	Alcoholism or drug habit?	❍ N ❍ Y

5.	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

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 (reorder CO-51340-MH), 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 _ _ / _ _ / _ _ _ _

If Medical Information Has Been Entered it Will Appear on the Following Page(s)

Waiver (refusal of coverage)

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

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

Medical for:	❍ 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)
Short Term Disability for:	❍ Myself		
Long Term Disability for:	❍ Myself		
Health Savings Account for:	❍ Myself		

Waive Coverage for Workplace Voluntary Benefits:

Whole Life for:	❍ Myself	❍ My spouse*	❍ My dependent child(ren)
Level Term Life for:	❍ Myself	❍ My spouse*	❍ My dependent child(ren)
Critical Illness for:	❍ Myself	❍ My spouse*	❍ My dependent child(ren)
Group Lump Sum Cancer for:	❍ Myself	❍ My spouse*	❍ My dependent child(ren)
Cancer Expense for:	❍ Myself	❍ My spouse*	❍ My dependent child(ren)
Supplemental Health for:	❍ Myself	❍ My spouse*	❍ My dependent child(ren)
Accident for:	❍ Myself	❍ My spouse*	❍ My dependent child(ren)
Disability Income Plus for:	❍ Myself		
Disability Income Advantage for:	❍ Myself		

I decline to apply for group coverage because of:

- ❍ Spousal/Partner to a civil union coverage
- ❍ Medicare supplement
- ❍ Individual coverage
- ❍ Coverage under another carrier's plan provided by my employer / group
- ❍ Other: _____

*Spouse also includes partner of a civil union

Last name:	First name:

Agreement

True and complete acknowledgement

I understand, agree, and represent:

- I have read the 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 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. I understand eligibility for enrollment does not apply to a High Deductible Health Plan (HDHP).
- In the event that I should decide to apply for coverage hereafter, that subsequent 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. I understand eligibility for enrollment does not apply to an HDHP.
- 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 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 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 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 void, reduce, or increase past premium, or terminate an individual's coverage or the group's coverage.
- 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 Group Employee and Individual Application and Enrollment Form by Humana.
- Any person who willingly and knowingly submits the Group Employee and Individual Application and Enrollment Form containing a false, incomplete or deceptive statement may be guilty of insurance fraud.
- It is unlawful to knowingly provide false, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

If you decide not to sign this agreement, we will decline to enroll you in an insurance product or to give you insurance benefits.

*Spouse also includes partner of a civil union

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 Life or Disability

If my dependents or I have selected life or 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 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.

Last name:	First name:

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.)

*Spouse also includes partner of a civil union

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 life or disability 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 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.

Employee Name: _____ Employee SSN: _____

Relationship	Name	Height (ft / in)	Weight (lbs)
Child			
Child			
Child			
Child			
Child			
Child			
Child			
Child			
Child			
Child			
Child			
Child			
Child			
Child			
Child			
Child			
Child			