

# Humana Employee Enrollment Application - 2-19 Employees

GEORGIA

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

HMO and POS plans offered by Humana Employers Health Plan of Georgia, Inc.

PPO and Classic Medical plans, Life and Short-Term Income Protection plans insured or administered by Humana Insurance Company.

Dental plans insured or administered by HumanaDental Insurance Company, Humana Insurance Company, CompBenefits Insurance Company or CompBenefits of Georgia, Inc.

CompBenefits Vision plan insured or administered by CompBenefits Insurance Company.

Please print clearly and fill in each applicable circle.

Medical Group number \_\_\_\_\_ Benefit number \_\_\_\_\_ Division \_\_\_\_\_

Company name \_\_\_\_\_ Proposed Effective Date \_\_/\_\_/\_\_\_\_

Company city \_\_\_\_\_ State \_\_\_\_\_

## Employee Information

GA-80124-GN 8/2007

Last name \_\_\_\_\_ First name \_\_\_\_\_ MI \_\_\_\_\_ Date of birth \_\_/\_\_/\_\_\_\_

Social Security number \_\_\_\_\_ Phone number \_\_\_\_\_

Gender:  Female  Male \_\_\_\_\_ Email address \_\_\_\_\_

Street address \_\_\_\_\_ Apt / Suite / PO Box number \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_ County \_\_\_\_\_

Language of choice:  English  Spanish

Employment status: Number of hours worked per week \_\_\_\_\_ Date of full-time hire \_\_/\_\_/\_\_\_\_  Full-time employee  Retiree

Are you disabled or unable to perform normal activities?  No  Yes If yes, indicate reason: \_\_\_\_\_

## Dependent Information

GA-80124-DP 8/2007

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:  Female  Male \_\_\_\_\_ Relationship:  Spouse  Child  Other: \_\_\_\_\_

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

### HMO and POS only:

Primary care physician \_\_\_\_\_ Physician ID \_\_\_\_\_ Current Patient:  No  Yes

**HMO and POS only:** Employee's nominated consumer choice option primary care physician \_\_\_\_\_ Current Patient:  No  Yes

2. Last name \_\_\_\_\_ First name \_\_\_\_\_ MI \_\_\_\_\_ Date of birth \_\_/\_\_/\_\_\_\_

Social Security number \_\_\_\_\_ Gender:  Female  Male \_\_\_\_\_ Relationship:  Spouse  Child  Other: \_\_\_\_\_

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

### HMO and POS only:

Primary care physician \_\_\_\_\_ Physician ID \_\_\_\_\_ Current Patient:  No  Yes

**HMO and POS only:** Employee's nominated consumer choice option primary care physician \_\_\_\_\_ Current Patient:  No  Yes

3. Last name \_\_\_\_\_ First name \_\_\_\_\_ MI \_\_\_\_\_ Date of birth \_\_/\_\_/\_\_\_\_

Social Security number \_\_\_\_\_ Gender:  Female  Male \_\_\_\_\_ Relationship:  Spouse  Child  Other: \_\_\_\_\_

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

### HMO and POS only:

Primary care physician \_\_\_\_\_ Physician ID \_\_\_\_\_ Current Patient:  No  Yes

**HMO and POS only:** Employee's nominated consumer choice option primary care physician \_\_\_\_\_ Current Patient:  No  Yes

Group Number

Social Security Number

**Medical** GA-80124-MD 8/2007

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

Plan name Network name

**HMO and POS only:**  
Employee primary care physician Physician ID Current Patient:  No  Yes

**HMO and POS only:** Employee's nominated consumer choice option primary care physician Current Patient:  No  Yes

**Concurrent medical coverage:**

• Will you or any of your covered dependents have any other individual or other group medical coverage, including Medicare, in effect at the same time as this Humana coverage?  No  Yes  
If yes, please complete below.

**Individual or other group medical coverage:**

Medical carrier name

Policy number Effective date \_\_/\_\_/\_\_\_\_

Carrier phone number Term date \_\_/\_\_/\_\_\_\_

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

**Medicare coverage:**

Employee Coverage:  No  Yes Effective date \_\_/\_\_/\_\_\_\_

Medicare ID Term date \_\_/\_\_/\_\_\_\_

Spouse Coverage:  No  Yes Effective date \_\_/\_\_/\_\_\_\_

Medicare ID Term date \_\_/\_\_/\_\_\_\_

**Prior medical coverage: (This section must be completed in order for Humana to process any medical claims.)**

• Within the past 12 months, have you or any of your covered dependents had any other individual or other group medical coverage, including Medicare?  No  Yes If yes, please complete below.

**Individual or other group medical coverage:**

Prior medical carrier name

Prior Policy number Effective date \_\_/\_\_/\_\_\_\_

Prior carrier phone number Term date \_\_/\_\_/\_\_\_\_

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

**Medicare coverage:**

Prior Employee Coverage:  No  Yes Effective date \_\_/\_\_/\_\_\_\_

Prior Medicare ID Term date \_\_/\_\_/\_\_\_\_

Prior Spouse Coverage:  No  Yes Effective date \_\_/\_\_/\_\_\_\_

Prior Medicare ID Term date \_\_/\_\_/\_\_\_\_

**Dental** GA-80124-HD 8/2007

Group number Benefit number Class/Division

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

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

**Basic Life** GA-80124-BL 8/2007

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** GA-80124-VL 8/2007

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) \$

**Vision** GA-80124-VS 8/2007

Group number Benefit number Class/Division

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

Plan name

**Evidence of Health Status** GA-80124-HS 8/2007

**This information should not be submitted more than 60 days prior to the effective date.**

Complete this section for employees and dependents enrolling for medical coverage who are members of groups with 2-19 applicants and applicants requesting Life insurance over the guarantee issue amount, and all late enrollees applying for Short-term income protection or Life coverage.

All medical questions should be answered in relation to treatment or diagnosis made by a medical professional or physician.

- 1. Are you or any dependent currently under any treatment or prescribed medications?  No  Yes
- 2. Have you or any dependent ever had, been diagnosed with, counseled, consulted or treated by a doctor for any of the following within the past 5 years:
  - a. Coronary artery disease, chest pain, or any disease of the arteries or blood vessels; phlebitis; high blood pressure?  No  Yes
  - b. Nervous, mental or emotional disorder; convulsions; epilepsy; unconsciousness?  No  Yes
  - c. Asthma or other disease of lungs or respiratory organs?  No  Yes
  - d. Kidney stones; disease of kidney, bladder, male or female organs; or infertility?  No  Yes
  - e. Cancer, and/or cancerous tumor? (state type; part of body)  No  Yes
  - f. Diabetes; liver or thyroid disease; or enlargement of the lymph nodes?  No  Yes
  - g. Stomach, gall bladder, intestinal or colon disorders?  No  Yes
  - h. Rheumatoid arthritis or back disorders?  No  Yes
  - i. Paralysis, or any other physical impairment or deformity?  No  Yes
  - j. Alcoholism or drug habit, or been a member of Alcoholics Anonymous?  No  Yes
- 3. Have you or any dependent ever been diagnosed or received treatment for an immune system disorder (i.e. Lupus, ITP), AIDS or an AIDS-related complex?  No  Yes
- 4. During the past 5 years, have you or any dependent had hospitalization or surgery scheduled or completed, had any injury, illness, medical attention or medical advice or treatment for any reason not already mentioned?  No  Yes
- 5. Are you or any eligible dependent enrolling for coverage pregnant?  No  Yes

6. Please provide height/weight information for all applicants enrolling for coverage:

a. Employee name	Height (ft / in)	Weight (lbs.)
b. Spouse name	Height (ft / in)	Weight (lbs.)
c. Dependent name	Height (ft / in)	Weight (lbs.)
d. Dependent name	Height (ft / in)	Weight (lbs.)
e. Dependent name	Height (ft / in)	Weight (lbs.)

**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 if necessary.**

Question number	Person treated last name	First name
Condition		
List symptoms encountered		
List treatments received		
List medical tests administered		
Medication(s) if any		
Date condition was first diagnosed __/__/____		Date last seen by a doctor for this condition __/__/____

Group Number

Social Security Number

**Short-Term Income Protection** GA-80124-SP 8/2007

Group number Benefit number Class/Division

Do you elect Short-Term Income Protection coverage?  No  Yes Annual salary \$

Class (employer will provide if needed)

**Health Savings Account** GA-80124-HA 8/2007

Group number Benefit number Class/Division

Do you elect the health savings account?  No  Yes

**If you have medical coverage under another plan, you may not be eligible for an HSA. Please check with your tax advisor for details. 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's estate. You may change beneficiary information on file with the bank that administers the HSA once the account is established.

**Waiver (Refusal of coverage)** GA-80124-WV 8/2007

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):

Medical for:  Myself  My spouse  My dependent child(ren) Vision for:  Myself  My spouse  My dependent child(ren)

Dental for:  Myself  My spouse  My dependent child(ren) Short-Term Income Protection for:  Myself

Basic life for:  Myself  My spouse  My dependent child(ren) Health savings account 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.
- 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.

**Agreement** GA-80124-AA 8/2007

**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 misrepresentation 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 misrepresentation materially affected the acceptance of the risk.
- Medical coverage will not be declined due to health status.
- I have received a copy of the plan provider directory and disclosure that includes provider limitation rules, and any financial arrangements with providers.

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: \_\_\_\_\_

Spouse signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Only if selecting Life coverage over the guarantee issue amount.)