

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. PPO, EPO and Indemnity plans offered by Humana Health Insurance Company of Florida, Inc. HMO plans offered by Humana Medical Plan, Inc. Prepaid, Basic, Intermediate and High Dental plans underwritten by The Dental Concern, Inc. Prepaid Capitol II and Universal II Dental plans 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 circle where applicable. Medical group number Class/sub group number Life/short term income protection/dental group number

Company name
 Company city State

Employee information FL-80124-GN

Last name First name MI
 Social security number Date of birth (MMDDYYYY) Phone number Gender: Female Male
 E-mail address
 Street address Apt / Suite / PO box number
 City State Zip code County
 Language of choice: English Spanish
 Employment status: Full-time employee. Number of hours worked per week: Retiree
 Date of full-time hire (MMDDYYYY)
 Are you disabled or unable to perform normal work activities? No Yes If yes, indicate reason: _____

Dependent information FL-80124-DP

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
 Social security number Date of birth (MMDDYYYY) Relationship: Spouse Child Other: _____
 Gender: Female Male Dependent status (if applicable): Full-time student Disabled If disabled, indicate reason: _____

HMO and POS only: (Not Applicable for Humana Access HMO)

Primary care physician Physician ID Current patient? No Yes
Prepaid: Network name
 Primary dentist Facility number Current patient? No Yes

2. Last name First name MI
 Social security number Date of birth (MMDDYYYY) Relationship: Spouse Child Other: _____
 Gender: Female Male Dependent status (if applicable): Full-time student Disabled If disabled, indicate reason: _____

HMO and POS only: (Not Applicable for Humana Access HMO)

Primary care physician Physician ID Current patient? No Yes
Prepaid: Network name
 Primary dentist Facility number Current patient? No Yes

Group number

Social Security number

Medical FL-80124-LG

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

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

Within the past 18 months, have you had any individual or other group medical coverage, including Medicare? No Yes

Prior medical carrier name Policy number

Prior carrier phone number Medicare ID Effective date Term date

Prior coverage type: Employee only Employee and spouse Employee and child(ren) Family Still in effect? No Yes

Dental FL-80124-HD

Group number	Benefit number	Class/Division
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Coverage type: Employee only Employee and spouse Employee and child(ren) Family Other:

Plan name

Prepaid: Network name

Primary dentist Facility number Current patient? No Yes

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 & spouse Employee & child(ren) Family

Basic Life FL-80124-HL

Group number	Benefit number	Class/Division
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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

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) \$

Short-term income protection FL-80124-SD

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

Class (employer will provide if needed)

Flexible spending account (if applicable) FL-80124-LG

Flexible health account No Yes Amount \$ Effective date Termination date

Flexible dependent care account No Yes Amount \$ Effective date Termination date



Waiver (refusal of coverage) FL-80124-LG

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

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: 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 dental or life with any future application for coverage.

Agreement FL-80124-AA

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 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.
 - 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.
 - Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer or health maintenance organization, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

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 practitioner, hospital, clinic, veterans administration facility, other medical or medically-related facility, Pharmacy Benefit Manager, insurance, HMO or reinsuring company, the Medical Information Bureau, Inc., or the Consumer Reporting Agency having information regarding myself and my dependents, including information concerning, advice, diagnosis, treatment and care of physical, psychiatric, mental or emotional conditions, drug, substance or alcohol abuse or illness, and any other non-medical information, to give any and all such information to Humana or their legal representative.

- 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 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 any application, claim or as may be otherwise lawfully required, or as we may further authorize.
 - We may request to receive a copy of this authorization.
 - 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.

Signature—please sign below if enrolling or waiving group coverage

Employee signature _____ Date _____