

## **Discrimination is Against the Law**

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Humana Inc. and its subsidiaries do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Humana Inc. and its subsidiaries provide:

- 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.
- Free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as translated documents or oral interpretation.

If you need these services, call 1-877-320-1235, or if you use a TTY, call 711.

If you believe that Humana Inc. and its subsidiaries have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

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 the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

### **U.S. Department of Health and Human Services**

200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201

**1-800-368-1019, 800-537-7697 (TDD)**

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

# Multi-Language Interpreter Services

**English:** ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-877-320-1235 (TTY: 711).

**Español (Spanish):** ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-320-1235 (TTY: 711).

**繁體中文 (Chinese):** 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-320-1235 (TTY: 711)。

**Tiếng Việt (Vietnamese):** CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-320-1235 (TTY: 711).

**한국어 (Korean):** 주의 : 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-320-1235 (TTY: 711)번으로 전화해 주십시오.

**Tagalog (Tagalog – Filipino):** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-320-1235 (TTY: 711).

**Русский (Russian):** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-320-1235 (телетайп: 711).

**Kreyòl Ayisyen (French Creole):** ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-320-1235 (TTY: 711).

**Français (French):** ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-320-1235 (ATS : 711).

**Polski (Polish):** UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-320-1235 (TTY: 711).

**Português (Portuguese):** ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-877-320-1235 (TTY: 711).

**Italiano (Italian):** ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-320-1235 (TTY: 711).

**Deutsch (German):** ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-320-1235 (TTY: 711).

**العربية (Arabic):**

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-320-1235 (رقم هاتف الصم والبكم: 711).

**日本語 (Japanese):** 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-877-320-1235 (TTY: 711) まで、お電話にてご連絡ください。

**فارسی (Farsi):**

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-877-320-1235 (TTY: 711) تماس بگیرید.

**Diné Bizaad (Navajo):** Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hóló, kojí' hódíílnih 1-877-320-1235 (TTY: 711).

**Large Group 101+ Employee and Individual Application and Enrollment Form**

**CALIFORNIA**

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in the Large Group 101+ Employee and Individual Application and Enrollment Form as "Humana".

Dental HMO underwritten by **LIBERTY Dental Plan of California, Inc.** and administered by **HumanaDental Insurance Company.**

**Print clearly and completely fill in each applicable circle.**

Employer / Group name

[Grid for Employer / Group name]

Employer / Group city

[Grid for Employer / Group city]

State

[Grid for State]

**Qualifying Event Instructions**

- 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)

[Grid for Qualifying event date]

Benefit effective date (MM/DD/YYYY)

[Grid for Benefit effective date]

**Office use only**

**Employee / Individual information**

Last name

[Grid for Last name]

First name

[Grid for First name]

MI

[Grid for MI]

Social Security Number

[Grid for Social Security Number]

Date of birth (MM/DD/YYYY)

[Grid for Date of birth]

Area code

[Grid for Area code]

Phone number

[Grid for Phone number]

Street address

[Grid for Street address]

Apt / Suite / PO box number

[Grid for Apt / Suite / PO box number]

Gender  Female  Male

City

[Grid for City]

State

[Grid for State]

Zip code

[Grid for Zip code]

County / Parish

[Grid for County / Parish]

E-mail address

[Grid for E-mail address]

Are you actively at work?  Yes  No If not, reason:

- Retiree
- COBRA
- Other: \_\_\_\_\_

Date of full-time hire (MM/DD/YYYY)

[Grid for Date of full-time hire]

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 \$

[Grid for Annual salary]

Hours worked per week

[Grid for Hours worked per week]

Occupation

[Grid for Occupation]

**Dependent information**

Enter information for each covered dependent, including spouse/domestic partner.

**1** Dependent last name  First name  MI  Gender  Female  Male

Social Security Number  -  -  Date of birth (MM/DD/YYYY)  /  /  Relationship  Spouse/Domestic partner  Child  Other: \_\_\_\_\_

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

**2** Dependent last name  First name  MI  Gender  Female  Male

Social Security Number  -  -  Date of birth (MM/DD/YYYY)  /  /  Relationship  Spouse/Domestic partner  Child  Other: \_\_\_\_\_

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

**3** Dependent last name  First name  MI  Gender  Female  Male

Social Security Number  -  -  Date of birth (MM/DD/YYYY)  /  /  Relationship  Spouse/Domestic partner  Child  Other: \_\_\_\_\_

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

**4** Dependent last name  First name  MI  Gender  Female  Male

Social Security Number  -  -  Date of birth (MM/DD/YYYY)  /  /  Relationship  Spouse/Domestic partner  Child  Other: \_\_\_\_\_

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

Use the following alternate address for these dependents:  1  2  3  4

Street address

Apt / Suite / PO box number

City  State  Zip code  County

**Dental**

- Coverage type:  Employee / Individual only  
 Employee / Individual & spouse/ domestic partner  
 Employee / Individual & child(ren)  
 Family  
 Other

**Office use only**

Group #	Benefit #	Class/Div #
<input type="text"/>	<input type="text"/>	<input type="text"/>

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/ domestic partner 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)
<input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>

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

Prior dental carrier name:	Orthodontia coverage?	Starting date (MM/DD/YYYY)	End date, if applicable (MM/DD/YYYY)
<input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>

Coverage type check all that apply)  Employee / Individual only  Employee / Individual and spouse/domestic partner  
 Employee / Individual and child(ren)  Family

DHMO	Employee primary care dentist name	Dentist ID #	Current patient?
	<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No
1 DHMO	Dependent primary care dentist name	Dentist ID #	Current patient?
	<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No
2 DHMO	<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No
3 DHMO	<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No

**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 below is evidence of this action.

<p>I hereby waive coverage for (check all that apply):                  Dental for: <input type="radio"/> Myself <input type="radio"/> My spouse/domestic partner <input type="radio"/> My dependent child(ren)</p>	<p>I decline to apply for group coverage because of:  <input type="radio"/> Spousal/Domestic partner coverage  <input type="radio"/> Medicare supplement  <input type="radio"/> Individual coverage  <input type="radio"/> Coverage under another carrier's plan provided by my employer / group  <input type="radio"/> Other: _____</p>
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**True and complete acknowledgement**

I understand, agree, and represent:

- I have read the Large Group 101+ 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 Large Group 101+ 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.
- In the event that I should decide to apply for coverage hereafter, that subsequent Large Group 101+ 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.
- If I am declining coverage for myself or my dependents (including my spouse/domestic partner) 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/domestic partner) 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 may delay coverage and/or deny coverage with any future submissions of the Large Group 101+ 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 I am applying for coverage for my dependents (including my spouse/domestic partner) I attest by my signature below, I have gathered the necessary health information from my dependents to the best of my knowledge to complete the Large Group 101+ Employee and Individual Application and Enrollment Form.
- To the best of my knowledge and belief, if I am applying for coverage for my dependents (including my spouse/domestic partner) I attest by my signature below, I have gathered the necessary health information from my dependents in order to complete the Small Group Employee and Individual Application and Enrollment Form.
- 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 101+ Employee and Individual Application and Enrollment Form by Humana.

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**

I understand and agree:

- The information collected in this application and enrollment form 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 101+ Employee and Individual Application and Enrollment Form, claim or as may be otherwise lawfully required, or as I (we) may further authorize.
- This authorization shall be valid for the length of coverage under the plan in regards to a claim determination, if the claim is for an accident and sickness insurance benefit.
- The authorization for collecting information in connection with an application for life, accident and sickness or disability insurance shall be valid for 30 months from the date the authorization is signed.
- A copy of this authorization is available to me or my legal representative upon request.

**The Large Group 101+ 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.**

**Signature - Please sign below if enrolling or waiving any group coverage**

To the best of my knowledge and belief, if I am applying for coverage for my dependents (including my spouse/domestic partner) I have gathered the necessary health information from my dependents in order to the best of my knowledge or belief complete the Group Employee and Individual Application and Enrollment Form.

Employee / Individual or legal representative signature

Date

 /  / 

Name and relationship of legal representative \_\_\_\_\_  
(if a covered dependent)

**Agent / Producer Information**

**In accordance with CA 2274.76, did you help or advise and/or answer questions regarding the application (including electronically), health questions, or health insurance for any applicant?**  N  Y

In accordance with CIC § 10119.3, to the best of my knowledge, the information on the application is complete and accurate, and I have explained to the applicant in easy-to-understand language, the risk to the applicant of providing inaccurate information and that the applicant understood the explanation.

As the Writing Agent / Producer, I acknowledge that I am responsible to meet with the primary applicant submitting the Large Group 101+ 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.