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'dęę', t'áá jiik'eh, éí ná hóló, kojį' 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, Life and Vision plans insured or adminisered by **Humana Insurance Company**.

Print clearly and completely fill in each applicable circle.

Employer / Group name

Employer / Group city

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_____

Office use only

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

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

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 #

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)

❍ Yes ❍ No

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)

❍ Yes ❍ No

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

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 /domestic partner 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/ domestic partner
❍ 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 IF YOU ARE SELECTING LIFE OVER THE GUARANTEE ISSUE AMOUNT.

1. Is anyone on this application currently taking any prescribed medication, or do you periodically take medication for a recurrent condition?	❍ No ❍ Yes ❍ Not sure
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	❍ No ❍ Yes ❍ Not sure
2b. Is any applicant currently a smoker? If yes, applies to: ❍ You (employee) ❍ Dependent 1 ❍ Dependent 2 ❍ Dependent 3 ❍ Dependent 4	❍ No ❍ Yes ❍ Not sure
3. In the past 1-12 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?	❍ No ❍ Yes ❍ Not sure

4.	To the best of your knowledge or belief, has any person listed on this application within the past 5 years, sought treatment, received treatment, or had treatment recommended by a medical professional, been surgically treated or been hospitalized for any of the following conditions?

a.	Ablation, Anemia, Angina, Angioplasty, Arteriosclerosis, Arrhythmia, Blood Clot, Bypass, Congestive Heart Failure, Heart attack, Heart Murmur, Hemophilia, High Blood Pressure(reading higher than 140/90), High Cholesterol, High Triglycerides, ICD Implant, Irregular Heart Beat, Pacemaker, Palpitations, Sickle Cell Anemia, Stent, Tachycardia or Varicose Veins?	❍ No ❍ Yes ❍ Not sure	h.	Diabetes, Hypothyroid, Hyperthyroid, Goiter, Hashimoto Disease, Cirrhosis, Hepatitis or Fatty Liver?	❍ No ❍ Yes ❍ Not sure
b.	Alcohol Abuse, Anorexia, Anxiety, ADD/ADHD, Autism, Drug Abuse, Cocaine Use, Marijuana Use, Opiate Use, Heroin Use, Methadone Use, Morphine Use, Bipolar, Bulimia, Depression, Manic Depression, Schizophrenia or Suicide Attempt?	❍ No ❍ Yes ❍ Not sure	i.	Colitis, Crohn's, colostomy (❍ total or ❍ partial), ileostomy (❍ total or ❍ partial) Diverticulitis, Gallbladder, GERD, Hernia, Intestinal Polyp, Pancreatitis, Reflux, ulcer, ulcerative colitis, gastric bypass/stapling?	❍ No ❍ Yes ❍ Not sure
c.	Stroke; Transient Ischemic Attack (TIA)?	❍ No ❍ Yes ❍ Not sure	j.	Amputation, Breast Implants, Chronic Fatigue Syndrome, Carpal Tunnel Syndrome, Fibromyalgia, Fracture, Gout, Herniated/Ruptured/Slipped Disc, Internal Derangement of the knee, Joint Replacement , Kyphosis, Lordosis, Muscular Dystrophy, Osteoarthritis, Rheumatoid Arthritis, Pins/Screws/Plates (❍ permanent ❍ temporary), Prosthetic Device, Scoliosis, Sciatica, Spina Bifida, Whiplash?	❍ No ❍ Yes ❍ Not sure
d.	Allergy Injections, COPD, Cystic Fibrosis, Emphysema, Pneumonia, Sarcoidosis, Sleep Apnea, Asthma, Bronchitis or Tuberculosis?	❍ No ❍ Yes ❍ Not sure	k.	ALS/Lou Gehrig's disease, Alzheimer's, Cerebral Palsy, Multiple Sclerosis, Paralysis or Parkinson's Disease, Seizure/Epilepsy?	❍ No ❍ Yes ❍ Not sure
e.	PSA, Renal Function Tests, Chronic Renal Disease, Congenital Malformation of Kidney and Ureter, Cystic Kidney, Dialysis, End Stage Renal Disease, Glomerulonephritis, Hydronephrosis, Kidney Stones, Kidney Transplant, Nephrectomy, Nephroptosis, Nephrotic Syndrome, Polycystic Kidney Disease or Renal Abscess?	❍ No ❍ Yes ❍ Not sure	l.	Cleft Palate/Lip, Club Foot, Developmental Delay, Mental Retardation, Down's Syndrome, anatomical defect of the heart, Skull or other physical deformities, Premature birth still receiving treatment?	❍ No ❍ Yes ❍ Not sure
f.	Menstrual Bleeding, Pap, Breast cyst/fibroid, Endometriosis, Human Papillomavirus (HPV), Ovarian Cysts, Polycystic Ovarian Syndrome, Benign Ovarian/Uterine Tumors or Uterine Fibroids?	❍ No ❍ Yes ❍ Not sure	m.	Eczema, chronic ear infections, chronic sinusitis, deviated septum, glaucoma, psoriasis, Retinal Degenerative Disease, burns second degree or above?	❍ No ❍ Yes ❍ Not sure
g.	Cancer:Basal Cell, Bladder, Blood, Bone, Breast, Brain, Cervical, Colon, Eye, Liver, Lung, Ovarian, Prostate, Stomach, Thyroid, Testicular, Lymph System, Esophageal, Leukemia, Lymphoma, Hodgkin's Disease, Melanoma, Metastasized, Squamous cell, Uterine?	❍ No ❍ Yes ❍ Not sure	n.	Received diagnosis or treatment from a member of the medical profession for Acquired Immune Deficiency Syndrome or AIDS-Related Complex? California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.	❍ No ❍ Yes ❍ Not sure

5.	Has any person listed on this application had treatment, surgery or hospitalization recommended by a member of the medical profession that has not been completed within the past 5 years?	❍ No ❍ Yes ❍ Not sure
6.	Within the past 5 years, has anyone on this application seen a health care provider or specialist for a routine physical/wellness exam, or been seen for any reason not previously disclosed?	❍ No ❍ Yes ❍ Not sure

Evidence of Health Status (continued)

	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			'	

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 CA-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) / /

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.

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

Dental for:	❍ Myself	❍ My spouse /domestic partner	❍ My dependent child(ren)
Basic Life for:	❍ Myself	❍ My spouse/domestic partner	❍ My dependent child(ren)
Vision for:	❍ Myself	❍ My spouse/domestic partner	❍ My dependent child(ren)

I decline to apply for group coverage because of:

- ❍ Spousal /Domestic partner coverage
- ❍ Medicare supplement
- ❍ Individual coverage
- ❍ Coverage under another carrier's plan provided by my employer / group
- ❍ Other:_____

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 Medi-cal 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 Medical 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 life or dental 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.

Authorization for Release of Medical Records for Life
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, information relating to eligibility, prior and other insurance coverage, and personal contact information, such as name, address, phone number to share any and all such information with the company checked below, its reinsurer or its legal representatives, and its affiliates.
CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH INSURANCE COMPANIES AS A CONDITION OF OBTAINING HEALTH INSURANCE COVERAGE.
❍ Humana Insurance Company

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

Will the coverage selected replace or change any existing life insurance policy(s) and/or annuity(s)? ❍ N ❍ Y

In accordance with 10 CCR § 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 infrmation 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.