HumanaDental Insurance Company

Small Group Employee and Individual Application and Enrollment Form - 1-100 Employees **CALIFORNIA**

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 dentist, please complete reorder CA-51340-PP.

Dental HMO underwritten by **LIBERTY Dental Plan of California, Inc.** and administered by **HumanaDental 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
- ○ Other_____
- ○ Open Enrollment event
- ○ New hire / Newly eligible
- ○ Rehire / Reinstatement

Special Enrollment:

- ○ Change in family status
- ○ Loss of coverage, including loss of minimum essential coverage
- ○ COBRA exhaustion
- ○ Termination of Medi-Cal, Healthy Families, AIM Program or CHIP
- ○ Eligibility for premium assistance under Medi-Cal, Healthy Families, AIM Program or CHIP
- ○ Eligibility for coverage including but not limited to: Released from incarceration; Access to new health plans as a result of a permanent move; Receiving services from a provider under another plan that is no longer participating in the plan; Misinformed you had minimum essential coverage Returning from active duty

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	

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 #

E-mail address | Occupation

Are you actively at work? ○ Y ○ N If not, reason: ○ Retiree ○ COBRA Other: _ | Annual salary $

Last name:	First name:

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

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:
	Effective date	○ Employee / Individual only ○ Employee / Individual and spouse / domestic partner ○ Employee / Individual and child(ren) ○ Family
Prior carrier phone #	Term date	

Coverage Options

Dental **Group #:** **Benefit #:** **Class/Div:**

Coverage type:
- ○ Employee / Individual only
- ○ Employee / Individual and spouse /domestic partner
- ○ Employee / Individual and child(ren)
- ○ Family
- ○ No Coverage (complete waiver)

Rate Amount $_____ Rate Frequency (Monthly)
Rate Amount $_____ Rate Frequency (Monthly)
Rate Amount $_____ Rate Frequency (Monthly)
Rate Amount $_____ Rate Frequency (Monthly)

Plan name:

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):	I decline to apply for group coverage because of:
Dental for: ○ Myself ○ My spouse/domestic partner ○ My dependent child(ren)	○ Spousal /Domestic partner coverage ○ Medicare supplement ○ Individual coverage ○ Coverage under another carrier's plan provided by my employer / group ○ Other:_____

Agreement

True and complete acknowledgment

I understand, agree, and represent:

- I have read the Small 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 Small 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.
- In the event that I should decide to apply for coverage hereafter, that subsequent Small 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.
- 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 Small Group Employee and Individual Application and Enrollment Form for coverage.

Last name: First name:

- 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 Small Group 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 Small Group 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 Group 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 Small 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.

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.
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: _____

Spouse /Domestic partner signature: _____ Date: _____

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 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 Small 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.