KY Assoc Builders and Contr 28300

Large Group 51+ Member / and Individual Application and Enrollment Form KENTUCKY

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

• **Humana Health Plan, Inc.**, 321 West Main Street, Louisville, KY 40202 • **Humana Insurance Company of Kentucky**, 500 West Main Street, Louisville, KY 40202 • **The Dental Concern, Inc.**, 500 West Main Street, Louisville, KY 40202

For PPO, HMO, or POS Medical plans, coverage is provided by Humana Health Plan, Inc., a Health Maintenance Organization. For Indemnity Medical plans, insurance coverage is provided or administered by Humana Insurance Company of Kentucky. For Dental and Vision, insurance coverage is provided or administered by The Dental Concern, Inc.

Print clearly and completely fill in each applicable circle.

Group name

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) / /

Member / 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

Language of choice ❍ English ❍ Spanish

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

HMO/POS only

Primary care physician name

Primary care physician ID #

Current patient? ❍ Yes ❍ No

HMO/POS only

OB/GYN Primary care physician name (if applicable)

Primary care physician ID #

Current patient? ❍ Yes ❍ No

Dependent information

Enter information for each covered dependent, including spouse.

1 Dependent last name | First name | MI | Gender ❍ Female ❍ Male

Social Security Number ___ - ___ - ____ | Date of birth (MM/DD/YYYY) __ / __ / ____ | Relationship ❍ Spouse ❍ Child ❍ Other:_____

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

Not applicable for HumanaAccess HMO

HMO/POS only — Primary care physician name | Primary care physician ID # | Current patient? ❍ Yes ❍ No

HMO/POS only — OB/GYN Primary care physician name (if applicable) | Primary care physician ID # | Current patient? ❍ Yes ❍ No

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2 Dependent last name | First name | MI | Gender ❍ Female ❍ Male

Social Security Number ___ - ___ - ____ | Date of birth (MM/DD/YYYY) __ / __ / ____ | Relationship ❍ Spouse ❍ Child ❍ Other:_____

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

Not applicable for HumanaAccess HMO

HMO/POS only — Primary care physician name | Primary care physician ID # | Current patient? ❍ Yes ❍ No

HMO/POS only — OB/GYN Primary care physician name (if applicable) | Primary care physician ID # | Current patient? ❍ Yes ❍ No

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3 Dependent last name | First name | MI | Gender ❍ Female ❍ Male

Social Security Number ___ - ___ - ____ | Date of birth (MM/DD/YYYY) __ / __ / ____ | Relationship ❍ Spouse ❍ Child ❍ Other:_____

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

Not applicable for HumanaAccess HMO

HMO/POS only — Primary care physician name | Primary care physician ID # | Current patient? ❍ Yes ❍ No

HMO/POS only — OB/GYN Primary care physician name (if applicable) | Primary care physician ID # | Current patient? ❍ Yes ❍ No

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4 Dependent last name | First name | MI | Gender ❍ Female ❍ Male

Social Security Number ___ - ___ - ____ | Date of birth (MM/DD/YYYY) __ / __ / ____ | Relationship ❍ Spouse ❍ Child ❍ Other:_____

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

Not applicable for HumanaAccess HMO

HMO/POS only — Primary care physician name | Primary care physician ID # | Current patient? ❍ Yes ❍ No

HMO/POS only — OB/GYN Primary care physician name (if applicable) | Primary care physician ID # | Current patient? ❍ Yes ❍ No

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

Street address

Apt / Suite / PO box number

City | State | Zip code | County

Medical – Humana Health Plan, Inc., 321 West Main Street, Louisville, KY 40202
Humana Insurance Company of Kentucky, 500 West Main Street, Louisville, KY 40202

Coverage type:
❍ Member / Individual only
❍ Member / Individual & spouse
❍ Member / Individual & child(ren)
❍ Family
❍ Other

Office use only
Group # | Benefit # | Class/Div #

Plan name | Network name

Do you or any covered dependent(s) currently have other medical coverage, such as a spouse's plan, another Humana medical plan, or Medicare? ❍ Yes ❍ No If yes, list all: (This section must be completed for Humana to process any medical claims.)

Medicare ID or medical carrier name:
Starting date (MM/DD/YYYY) / /
End date, if applicable (MM/DD/YYYY) / /
Coverage Type (check all that apply)
❍ Member / Individual
❍ Spouse
❍ Child(ren)

Medicare ID or medical carrier name:
Starting date (MM/DD/YYYY) / /
End date, if applicable (MM/DD/YYYY) / /
Coverage Type (check all that apply)
❍ Member / Individual
❍ Spouse
❍ Child(ren)

Have you or any covered dependent(s) had medical insurance from a company (including another Humana plan) in the past 18 months? ❍ Yes ❍ No If yes, list all: (This section must be completed for Humana to process any medical claims.)

Prior medical carrier name:
Starting date (MM/DD/YYYY) / /
End date, if applicable (MM/DD/YYYY) / /
Coverage Type (check all that apply)
❍ Member / Individual
❍ Spouse
❍ Child(ren)

Prior medical carrier name:
Starting date (MM/DD/YYYY) / /
End date, if applicable (MM/DD/YYYY) / /
Coverage Type (check all that apply)
❍ Member / Individual
❍ Spouse
❍ Child(ren)

Medical Health History - Do not submit more than 90 days prior to the effective date

1. Within the past 24 months have you or any dependent to be covered had or been treated for an illness or injury, had surgery or hospitalization recommended, or are currently pregnant? ❍ N ❍ Y
2. Within the past 24 months have you or any dependent to be covered been prescribed medication? ❍ N ❍ Y
3. Have you or any dependent to be covered incurred medical expenses in excess of $7,500 in the past12 months? ❍ N ❍ Y

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 KY-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) / /

Health Savings Account (HSA) Applicable only with High Deductible Health Plan selection

Do you elect the Health Savings Account?
❍ Yes ❍ No If no, complete waiver section

If you have medical coverage under another plan, you may not be eligible for an HSA. Please check with your tax advisor for details.

Office use only
Group # Benefit # Class/Div #

Please refer to Humana's HSA contribution worksheet to calculate your maximum allowed contribution. 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 / individual 's estate. You may change beneficiary information on file with the bank that administers the HSA once the account is established.

Dental – The Dental Concern, Inc., 500 West Main Street, Louisville, KY 40202

Coverage type:
❍ Member / Individual only
❍ Member / Individual & spouse
❍ Member / 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 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? ❍ Yes ❍ No | Starting date (MM/DD/YYYY) / / | End date, if applicable (MM/DD/YYYY) / /

Coverage Type (check all that apply) ❍ Member / Individual ❍ Spouse ❍ Child(ren)

Prior dental carrier name: | Orthodontia coverage? ❍ Yes ❍ No | Starting date (MM/DD/YYYY) / / | End date, if applicable (MM/DD/YYYY) / /

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

	Member primary care dentist name	Dentist ID #	Current patient?
DHMO			❍ Yes ❍ No
	Dependent primary care dentist name	Dentist ID #	Current patient?
1 DHMO			❍ Yes ❍ No
2 DHMO			❍ Yes ❍ No
3 DHMO			❍ Yes ❍ No

In the event that an application is submitted outside of an open enrollment period, without a qualifying event, or by submitting an incomplete enrollment form Humana reserves the right to delay coverage.

Vision – The Dental Concern, Inc., 500 West Main Street, Louisville, KY 40202

Coverage type:
❍ Member / Individual only
❍ Member / Individual & spouse
❍ Member / Individual & child(ren)
❍ Family
❍ Other

Office use only
Group # Benefit # Class/Div #

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 below is evidence of this action.

I hereby waive coverage for (check all that apply):		I decline to apply for group coverage because of:
Medical for:	❍ Myself ❍ My spouse ❍ My dependent child(ren)	❍ Spousal coverage
Dental for:	❍ Myself ❍ My spouse ❍ My dependent child(ren)	❍ Medicare supplement
Vision for:	❍ Myself ❍ My spouse ❍ My dependent child(ren)	❍ 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 Member / 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 Member / 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 an application is submitted outside of an open enrollment period, without a qualifying event, or by submitting an incomplete enrollment form, Humana reserves the right to delay coverage.
- Based on the coverage I have elected, I may be required to furnish evidence of health status satisfactory to Humana.
- If I am declining coverage for myself or my dependents (including my spouse) 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) 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 reserves the right to delay medical coverage and/or deny life or dental coverage with any future submissions of the Large Group Member / and Individual Application and Enrollment Form for coverage.
- If any deductions are required for this coverage, I authorize those deductions from my earnings. If selecting the Health Savings Account (HSA), I authorize Humana or its banking partners to provide my account number to my employer / group for the purposes of depositing any contributions.
- If I am applying for coverage for my dependents (including my spouse) I attest by my signature below, I have gathered the necessary health information from my dependents in order to fully and truthfully complete the Large Group Member / and Individual Application and Enrollment Form.
- If I have selected workplace voluntary benefits, and if coverage is not issued as initially applied for, I hereby authorize Humana to decrease or increase the premium or rate amount stated on the Large Group Member / and Individual Application and Enrollment Form to cover the benefit actually issued.
- Intentional fraud or intentional misrepresentation of a material fact may void, reduce or increase past premium, or terminate an individual's coverage or group's coverage.
- Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.
- 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 Member / and Individual Application and Enrollment Form by Humana.
- Any person who willingly and knowingly submits the Large Group Member / and Individual Application and Enrollment Form containing a false, incomplete or deceptive statement may be guilty of insurance fraud.

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

My dependents and I understand and agree:

- The information obtained by use of this authorization may 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 Member / 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 twenty-four (24) months from the date shown below and I have the right to revoke this authorization at any time by writing to Humana's Privacy Office.

Authorization for Release of Medical Records for Life or Disability
If my dependents or I have selected life or disability, I authorize Humana, its reinsurer or its legal representatives, and its affiliates to have information. Any information obtained will not be released by the company 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, the recipient may redisclose it and the information may not be protected by federal and state privacy requirements.

The Large Group Member / 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

Member / Individual or legal representative signature _____ Date ☐☐ / ☐☐ / ☐☐☐☐

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

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.