Humana Large Group Employee Enrollment Form

The offering company(ies) listed on the signature page, severally or collectively, as the content may require, are referred to in this application as "Humana". Print clearly and completely fill in each applicable circle.

Company name: Grundy County Special Education Cooperative

Company city:

State: IL

Office use only

Qualifying event:
❍ Open Enrollment ❍ Re-hire
❍ New hire ❍ Changed to full time status

Qualifying event date (MM/DD/YYYY) / /

Benefit effective date (MM/DD/YYYY) / /

Employee 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

Employment state ❍ Full-time employee ❍ Retiree

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

Are you disabled or unable to perform normal work activities? ❍ No ❍ Yes If yes, indicate reason: _____

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 (18 or older) ❍ 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 ❍ Child ❍ Other:_____

Dependent status (if applicable): ❍ Full-time student (18 or older) ❍ 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 ❍ Child ❍ Other:_____

Dependent status (if applicable): ❍ Full-time student (18 or older) ❍ Disabled If disabled, indicate reason: _____

Last name: | First name:

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 (18 or older) ❍ 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 / Parish

Medical

Coverage type:
❍ Employee only
❍ Employee & spouse
❍ Family
❍ Employee & child(ren)
❍ Other: _____

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

Plan name ChoicePOS 90-70 | Network name

- Will you or any covered family member have any other medical coverage, such as Medicare or a spouse's medical coverage in effect at the same time as this Humana coverage? ❍ Yes ❍ No If yes, list all:

Medicare ID or medical carrier name:

Starting date (MM/DD/YYYY) / /

End date, if applicable (MM/DD/YYYY) / /

Covered member (check all that apply)
❍ Employee
❍ Spouse
❍ Child(ren)

Medicare ID or medical carrier name:

Starting date (MM/DD/YYYY) / /

End date, if applicable (MM/DD/YYYY) / /

Covered member (check all that apply)
❍ Employee
❍ Spouse
❍ Child(ren)

- Besides those listed above, within the last 18 months, have you or any covered family member had any medical coverage, such as Medicare or a spouse's medical coverage? ❍ 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) / /

Covered member (check all that apply)
❍ Employee
❍ Spouse
❍ Child(ren)

Prior medical carrier name:

Starting date (MM/DD/YYYY) / /

End date, if applicable (MM/DD/YYYY) / /

Covered member (check all that apply)
❍ Employee
❍ Spouse
❍ Child(ren)

Last name: First name:

Dental

Coverage type: ❍ Employee only
❍ Employee & spouse
❍ Family
❍ Employee & child(ren)
❍ Other: _____

Office use only
Group # Benefit # Class/Div #

Plan name Traditional Preferred 100-80-50

- Within the past 12 months, have you or any covered family member 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)

	Orthodontia coverage?	Starting date (MM/DD/YYYY)	End date, if applicable (MM/DD/YYYY)
Current dental carrier name:	❍ Yes ❍ No	/ /	/ /
Covered member (check all that apply) ❍ Employee ❍ Spouse ❍ Child(ren)			
Prior dental carrier name:	❍ Yes ❍ No	/ /	/ /
Covered member (check all that apply) ❍ Employee ❍ Spouse ❍ Child(ren)			

Vision

Coverage type: ❍ Employee only
❍ Employee & spouse
❍ Family
❍ Employee & child(ren)
❍ Other: _____

Office use only
Group # Benefit # Class/Div #

Plan name VCP

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. 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)
Vision for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)

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: _____

Last name: First name:

Insuring companies ILLINOIS

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in this application as "Humana". HMO plans offered by Humana Health Plan, Inc. PPO and Traditional Preferred plans, Life and Short-Term Income Protection plans insured or administered by Humana Insurance Company. Dental PPO and Traditional Preferred plans insured or administered by HumanaDental Insurance Company or Humana Insurance Company. Dental prepaid plans and AdvantagePlus dental plans offered and administered by CompBenefits Dental, Inc. CompBenefits Vision plan insured and administered by CompBenefits Insurance Company.

True and complete acknowledgement

I understand, agree and represent:

- I have read this document 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 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 this application for coverage is accepted, coverage will be effective on the date specified by Humana on the certificate of coverage/ certificate of insurance. 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 with in 31 days after the qualifying event.
- In the event that I should decide to apply for coverage hereafter, that subsequent application shall be subject to the applicable terms and conditions of the master group contract(s) or plan provisions 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.
- Humana reserves the right to delay medical coverage and/or deny life or dental coverage with any future application 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 for the purposes of depositing any contributions.
- Any misrepresentation contained herein relied on by Humana may be used to reduce or deny a claims or void the contract within the contestable period if such misrepresentation materially affected the acceptance of the risk.

Authorization

My dependents and I authorize any third party to have information regarding myself. This includes any medical or non-medical information and to share any and all such information with Humana, its reinsurer or its legal representatives, and its affiliates.

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 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.
- 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 and I have the right to revoke this authorization at any time by writing to Humana's Privacy office.

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.

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

Employee or legal representative signature _____ Date / /

Name and relationship of legal representative _____