Large Group Employee and Individual Application and Enrollment Form

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

Life plans insured or administered by Humana Insurance Company or Kanawha Insurance Company. Dental plans insured or administered by HumanaDental Insurance Company or Humana Insurance Company. Vision plans insured or administered by Humana Insurance Company. Short Term Disability,and Long Term Disability,and Workplace Voluntary Benefits plans insured or administered by Kanawha Insurance Company.

Print clearly and completely fill in each applicable circle.

Employer / Group name: New Milford Public Schools

Employer / Group city

State: CT

Qualifying Event Instructions — **Office use only**

- ○ New business enrollment
- ○ New hire/Newly eligible
- ○ Dependent birth or adoption
- ○ Open Enrollment event
- ○ Rehire/Reinstatement
- ○ Loss of coverage
- ○ Marital status change
- ○ Other_____

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 | Language of choice ○ English ○ Spanish

City | State | Zip code | County / Parish

E-mail address

Employment status ○ Full-time employee / individual ○ Retiree ○ COBRA | 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

Last name: First name:

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:_____

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:_____

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:_____

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:_____

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

Street address

Apt / Suite / PO box number

City | State | Zip code | County

Last name: First name:

Vision

Office use only Group # Benefit # Class/Div #

Covered individual ○ Employee / Individual only ○ Employee / Individual and spouse ○ Employee / Individual and child(ren) ○ Family ○ Other

Plan name

Short Term Disability

Do you elect short term disability coverage?
○ Yes ○ No If no, complete waiver section

Office use only Group # Benefit # Class # Div #

Buy-up percent/amount _____

Long Term Disability

Do you elect long term disability coverage?
○ Yes ○ No If no, complete waiver section

Office use only Group # Benefit # Class # Div #

Buy-up percent/amount _____

Group Term Life / AD&D

Office use only Group # Benefit # Class # Div #

Coverage requested for (check all that apply)		Coverage requested (complete only if plan provides a choice of benefit schedules)	Cost per pay period
Employee / Individual	○ Basic Term Life		$, .00
	○ Supplemental Term Life*		$, .00
	○ Basic AD&D		$, .00
	○ Supplemental AD&D		$, .00
Spouse	○ Basic Term Life		$, .00
	○ Supplemental Term Life*		$, .00
	○ Basic AD&D		$, .00
	○ Supplemental AD&D		$, .00
Child(ren)	○ Basic Term Life		$, .00
	○ Supplemental Term Life*		$, .00
	○ Basic AD&D		$, .00
	○ Supplemental AD&D		$, .00

*Complete Evidence of Insurability form if selecting one of these benefit amounts.

Last name: First 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):

Dental for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Basic Life for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Voluntary Life for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Vision for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Group Term Life for:	❍ Myself		
Short Term Disability for:	❍ Myself		
Long Term Disability for:	❍ Myself		
Waive Coverage for Workplace Voluntary Benefits:			
Whole Life for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Level Term Life for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Critical Illness Expense for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Group Lump Sum Cancer for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Supplemental Health for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Accident for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Disability Income Plus for:	❍ Myself		
Disability Income Advantage for:	❍ Myself		

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 / group
- ❍ Other: _____

True and complete acknowledgement

I understand, agree, and represent:

- I have read the Large 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 Large 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 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 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 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 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.
- 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.
- Humana reserves the right to 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 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 Employee 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 Employee and Individual Application and Enrollment Form to cover the benefit actually issued.
- An act of fraud or an intentional misrepresentation of a material fact may void or terminate an individual's or group's coverage as specified under the terms of the Policy or Certificate. Providing incomplete, inaccurate, or untimely information may void, reduce, or increase past premium, or terminate an individual's coverage or the group's coverage.
- 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 Employee and Individual Application and Enrollment Form by Humana.
- Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

If you decide not to sign this agreement, we will decline to enroll you in an insurance product or to give you insurance benefits.

Last name: First name:

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 this Large Group Employee and Individual Application and Enrollment Form, claim or as may be otherwise lawfully required, or as I (we) may further authorize.

Authorization for Release of Medical Records for Life or Disability

If my dependents or I have selected life or disability, 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. 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 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

If you are already covered by Medicaid, you are not eligible for Critical Illness coverage.

Employee / Individual or legal representative signature _____ Date ___/___/_____

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

Agent / Producer Information

If applying for workplace voluntary benefits, this section to be completed by Agent or Producer.

1. Agent / Agency of Record:

Name (print)

Humana Agent #

Commission split:

2. Agent / Agency of Record:

Name (print)

Humana Agent #

Commission split:

1. Writing Agent / Producer:

Name (print)

Humana Agent #

Commission split:

2. Writing Agent / Producer:

Name (print)

Humana Agent #

Commission split:

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

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