

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in this application as "Humana." Medical plans provided by Humana Health Benefit Plan of Louisiana, Inc. Life and Short-term income protection plans insured or administered by Humana Insurance Company. Dental plans insured or administered by HumanaDental Insurance Company or Humana Insurance Company.

Please print clearly and fill in each circle where applicable.

Group number

Benefit number

Class/Division

Employee information

Last name First name MI
Member ID Employer name

Change employee address information

New street address Apt / Suite / PO box number
City State Zip code
E-mail address Phone number

Change or select primary care physician (HMO and POS only)

Employee's primary care physician Physician ID
Dependent last name First name MI
Dependent's primary care physician Physician ID

Change plans or dependents

- Change plan from to
If changing to an HMO or POS plan, please select a primary care physician and enter above.
- Change benefit / class to: Benefit number Class/division
- Add dependent (complete Dependent Information form and any applicable enrollment forms)
- Delete dependent (complete Dependent Information form and any applicable enrollment forms)
- Cancel coverage: Termination date (MMDDYYYY)

Indicate qualifying event:

- Re-hire Divorce Dependent birth / adoption
- Legal separation Spouse's employer terminates coverage Other:
- Employer contribution ceases Spouse deceased Qualifying event date (MMDDYYYY)
- Spouse changes from full-time to part-time employment Spouse terminates employment

Change beneficiary

Basic Life

Primary beneficiary name Secondary beneficiary name

Voluntary Life

Primary beneficiary name Secondary beneficiary name

Employee social security number - -

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: _____
Primary care physician name Primary care physician ID # Current patient? Yes No
HMO/POS only:

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: _____
Primary care physician name Primary care physician ID # Current patient? Yes No
HMO/POS only:

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: _____
Primary care physician name Primary care physician ID # Current patient? Yes No
HMO/POS only:

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: _____
Primary care physician name Primary care physician ID # Current patient? Yes No
HMO/POS only:

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

True and complete acknowledgement

I understand, agree and represent:

- I have read this document or it has been read to me.
- The answers provided within this entire application for coverage are to the best of my knowledge and belief, true and complete.
- Neither my employer nor the agent has the authority to waive a complete answer to 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.
- Any misrepresentation contained herein relied on by Humana may be used to reduce or deny a claim or void the contract within the contestable period if such misrepresentation materially affected the acceptance of the risk.
- Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I hereby enroll for benefits for which I am presently eligible or for which I may become eligible under my employer's group contract(s). If any deductions are required for this coverage, I authorize such deductions from my earnings. I reserve the right to revoke this deduction authorization at any time upon written notice unless I have chosen to use pretax deductions.

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.

Authorization

My dependents applying for coverage 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, non-public personal health information, and any other non-medical information to share any and all such information with Humana, its reinsurer or its legal representatives, and its affiliates.

My dependents applying for coverage and I understand and agree:

- The information obtained by use of this authorization may be used by Humana to determine eligibility for coverage, eligibility for benefits under an existing policy, plan administration, and make claim determinations.
- 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 we may further authorize.
- Once personal and health (including medical, dental and pharmacy) information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal and state privacy requirements.
- A copy of this authorization is available to me or my legal representative upon written request.
- 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 or until the date your coverage terminates, whichever occurs first.
- I have the right to revoke this authorization at any time:
 - To revoke this authorization, I must do so in writing and send my written revocation to Humana's Privacy Office.
 - The revocation will not apply to information that has already been released in response to this authorization.
 - The revocation will become effective after it is received by Humana's Privacy Office.

Signature—please sign below if enrolling or waiving group coverage

Employee or legal representative signature:

Date:

Name and relationship of legal representative: _____

Spouse signature:
(If covered dependent)

Date:

Child signature:
(If covered dependent)

Date: