

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in this application as "Humana." Life and Short Term income protection plans insured or administered by Humana Insurance Company. PPO, EPO and Indemnity plans offered by Humana Health Insurance Company of Florida, Inc. HMO plans offered by Humana Medical Plan, Inc. Prepaid, Basic, Intermediate and High Dental plans underwritten by The Dental Concern, Inc. Prepaid Capitol II and Universal II Dental plans provided by SafeGuard Health Plans, Inc. All other Dental plans insured or administered by HumanaDental Insurance Company or Humana Insurance Company.

Medical Group number

Benefit number

Class/Division

Please print clearly and fill in each circle where applicable.

**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 or select primary care dentist**

Group number  Employee's primary care dentist  Facility number   
 Employee's primary care clinic   
 Dependent last name  First name  MI   
 Dependent's primary care dentist  Dental Network   
 Dependent's primary care clinic  Facility number

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



**Change beneficiary**

**Basic Life**

Primary beneficiary name \_\_\_\_\_ Secondary beneficiary name \_\_\_\_\_

**Voluntary Life**

Primary beneficiary name \_\_\_\_\_ Secondary beneficiary name \_\_\_\_\_

**Agreement** **FL-80124-AA**

**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 affect the acceptance of the risk.
- 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.

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 and I authorize any physician, medical practitioner, hospital, clinic, veterans administration facility, other medical or medically-related facility, Pharmacy Benefit Manager, insurance, HMO or reinsuring company, the Medical Information Bureau, Inc., or the Consumer Reporting Agency having information regarding myself and my dependents, including information concerning, advice, diagnosis, treatment and care of physical, psychiatric, mental or emotional conditions, drug, substance or alcohol abuse or illness, and any other non-medical information, to give any and all such information to Humana or their legal representative.

My dependents 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 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 any application, claim or as may be otherwise lawfully required, or as we may further authorize.
- We may request to receive a copy of this authorization.
- 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.

Employee signature:

Date:

Spouse signature:

Date:

(If covered dependent)

