Humana Employee Enrollment Application — CALIFORNIA

Dental, Life & Vision

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in this application as "Humana."

Life & Vision plans insured or administered by Humana Insurance Company. Dental HMO plans underwritten by Golden West Dental and Vision. All other Dental plans insured or administered by HumanaDental Insurance Company or Humana Insurance Company.

Please print clearly and fill in each applicable circle.

Dental Group number | Benefit number | Division

Company name | Proposed Effective Date __ / __ / ____

Company city | State

Employee Information

CA-80124-GN 7/2007

Last name | First name | MI | Date of birth __ / __ / ____

Social Security number | Phone number

Gender: ❍ Female ❍ Male | Email address

Street address | Apt / Suite / PO Box number

City | State | Zip code | County

Language of choice: ❍ English ❍ Spanish

Employment status: Number of hours worked per week | Date of full-time hire __ / __ / ____ | ❍ Full-time employee ❍ Retiree

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

Dependent Information

CA-80124-DP 7/2007

Please enter information for each dependent, including spouse, applying for coverage. For additional dependents, copy and attach an additional Dependent Information form.

1. Last name | First name | MI | Date of birth __ / __ / ____

   Social Security number | Gender: ❍ Female ❍ Male | Relationship: ❍ Spouse ❍ Child ❍ Other:

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

   DHMO: Primary dentist | Facility number | Current Patient: ❍ No ❍ Yes

2. Last name | First name | MI | Date of birth __ / __ / ____

   Social Security number | Gender: ❍ Female ❍ Male | Relationship: ❍ Spouse ❍ Child ❍ Other:

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

   DHMO: Primary dentist | Facility number | Current Patient: ❍ No ❍ Yes

3. Last name | First name | MI | Date of birth __ / __ / ____

   Social Security number | Gender: ❍ Female ❍ Male | Relationship: ❍ Spouse ❍ Child ❍ Other:

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

   DHMO: Primary dentist | Facility number | Current Patient: ❍ No ❍ Yes

4. Last name | First name | MI | Date of birth __ / __ / ____

   Social Security number | Gender: ❍ Female ❍ Male | Relationship: ❍ Spouse ❍ Child ❍ Other:

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

   DHMO: Primary dentist | Facility number | Current Patient: ❍ No ❍ Yes

Group Number	Social Security Number

Dental

CA-80124-HD 7/2007

Group number | Benefit number | Class/Division

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

Plan name

DHMO: Primary dentist | Facility number | Current Patient: ❍ No ❍ Yes

Within the past 12 months, have you had any individual or other group dental coverage? ❍ No ❍ Yes Orthodontia coverage? ❍ No ❍ Yes

Effective date _ _ / _ _ / _ _ _ _ Term date _ _ / _ _ / _ _ _ _

Prior coverage type: ❍ Employee only ❍ Employee and spouse ❍ Employee and child(ren) ❍ Family

Basic Life

CA-80124-HL 7/2007

Group number | Benefit number | Class/Division

Primary beneficiary name | Secondary beneficiary name

Class (employer will provide you with this information if needed) | Annual salary (if applicable) $

Basic dependent life: ❍ No ❍ Yes If no, complete waiver section.

Voluntary Life

Group number | Benefit number | Class/Division

Do you elect voluntary employee life coverage? ❍ No ❍ Yes Amount (minimum of $15,000) $ Annual salary $

Primary beneficiary name | Secondary beneficiary name

Voluntary dependent life: (available only if employee elects voluntary life coverage) Do you elect voluntary child(ren) life coverage? ❍ No ❍ Yes

Do you elect voluntary spouse life coverage? ❍ No ❍ Yes Amount (minimum of $5,000) $

Vision

CA-80124-VS 7/2007

Group number | Benefit number | Class/Division

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

Plan name

Waiver (Refusal of coverage)

CA-80124-WV 7/2007

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):

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

Basic life for: ❍ Myself ❍ My spouse ❍ My dependent child(ren)

I decline to apply for group coverage because of (check all that apply): ❍ Spousal coverage ❍ Medicare supplement ❍ Individual coverage ❍ Coverage under another carrier's plan provided by my employer ❍ Other:

I understand and agree:

- In the event that I should decide to apply for such coverage hereafter, that such subsequent application shall be subject to the applicable terms and conditions of the master group contract(s) or plan provisions as described in the Summary Plan Description 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.
- If I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents provided that I request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.
- Humana reserves the right to delay medical coverage and/or deny life or dental coverage with any future application for coverage.

Group Number | Social Security Number

Agreement

CA-80124-AA 7/2007

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.
- Medical and life domestic partner coverage eligibility is subject to my domestic partner and I being of the same sex or the opposite sex if either of us are over age 62.

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 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 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.
- If you decide not to sign this authorization, Humana can not complete your plan enrollment or determine your premium rate due to the inability to obtain the necessary information.
- Any information obtained will not be released by Humana to any person or organization except to reinsuring companies, the Medical Information Bureau, Inc. or insurance support 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, 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.
- 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.

CALIFORNIA PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH INSURANCE COMPANIES AS A CONDITION OF OBTAINING HEALTH INSURANCE COVERAGE.

Signature - please sign below if enrolling or waiving group coverage

Employee or legal representative signature: ______________________ Date: ____________

Name and relationship of legal representative: ______________________

Spouse signature: ______________________ Date: ____________

(Only if selecting Life coverage over the guarantee issue amount.)

No Cost Language Services

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card. For more help call the CA Dept. of Insurance at 1-800-927-4357. (English)

Servicios de idiomas sin costo. Puede obtener un intérprete. Le pueden leer documentos y que le envíen algunos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación. Para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357. (Spanish)

خدمات ترجمة بدون تكلفة. يمكنك الحصول على مترجم فوري و قراءة الوثائق لك باللغة العربية. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك. للحصول على المزيد من المعلومات، اتصل بإدارة التأمين لولاية كاليفورنيا على الرقم 1-800-927-4357. (Arabic)

Անվճար լեզվական ծառայություններ: Դուք կարող եք թարգմանիչ ձեռք բերել: Դուք կարող եք փաստաթղթերն ընթերցել տալ ձեզ համար եւ դրանց որոշ մասը կարող է ձեզ ուղարկվել ձեր լեզվով: Օգնության համար զանգահարեք մեզ ձեր ինքնության (ID) քարտի վրա նշված համարով: Լրացուցիչ օգնության համար զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք 1-800-927-4357 համարով: (Անգլերեն) (Armenian)

免費語言服務。 您可獲得口譯員服務，用漢語把文件唸給您聽，並且把部分漢語文件發送給您。
欲取得協助，請撥打您的ID卡上所列示的電話號碼與我們聯絡。欲取得其他協助，請致電
1-800-927-4357 （英語）與加州保險部聯絡。 (Chinese)

Kev Pab Txhais Lus Tsis Yuav Nqi. Koj muaj peev xwm thov tau neeg txhais lus rau koj. Koj muaj peev xwm thov kom neeg nyeem ntawv rau koj thiab xav ntawv rau koj ua koj cov lus. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj nrog cev (ID card). Yog xav tau kev pab ntxiv hu rau CA lub Rooj Tsav Xwm Saib Xyuas Kev Faj Seeb ntawm 1-800-927-4357 (Hmong)

無料の言語サービス　日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、IDカ ード記載の番号までご連絡ください。詳細については、カリフォルニア州保険庁 1-800-927-4357（英語）まで電話でお問い合わせください。(Japanese)

សេវាកម្មឥតគិតថ្លៃ។ អ្នក អាចទទួលបានអ្នកបកប្រែភាសា និង អានឯកសារជូនអ្នក។ សម្រាប់ជំនួយ
សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខដែលមានបង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក។ សម្រាប់ជំនួយបន្ថែមទៀត
សូមទូរស័ព្ទទៅឈ្រក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រញ៉ា តាមលេខ 1-800-927-4357 (Khmer)

무료 언어지원 서비스. 귀하는 한국어 통역 서비스를 받으실 수 있습니다. 한국어로 문서를 낭독해주는 서비스를 받으시거나 한국어로 된 문서를 받으실 수 있습니다. 도움이 필요하신 분은 귀하의 ID카드에 나와있는 안내 전화로 문의해 주십시오. 보다 자세한 사항을 문의하실 분은 캘리포니아 주 보험국, 안내 전화 1-800-927-4357 번으로 연락해 주십시오. (Korean)

خدمات مجاني مربوط به زبان. میتوانید خدمات یك مترجم شفاهي استفادة کنید و بگوئید مدارك به زبان فارسي برايتان خوانده و يا فرستاده شوند برای دریافت کمك، با ما از طريق شماره تلفنی که روی کارت شناسائي شما قيد شده است تماس بگيريد. برای دریافت کمك بیشتر، به CA Dept. of Insurance (اداره بیمه کالیفرنیا) به شماره 1-800-927-4357تلفن کنید. (Persian)

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਹਾਨੂੰ ਕੁਈ ਦੁਭਾਸ਼ੀਆ ਮਿਲ ਸਕਦਾ ਹੈ। ਤੁਹਾਨੂੰ ਦਸਤਾਵੇਜ਼ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ ਅਤੇ ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਤੁਹਾਨੂੰ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਸਾਨੂੰ ਫ਼ੋਨ ਕਰੋ। ਵਧੇਰੇ ਮਦਦ ਲਈ ਕੈਲੀਫ਼ੋਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸ਼ੋਰੈਂਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫ਼ੋਨ ਕਰੋ। (ਅੰਗ੍ਰੇਜ਼ੀ) (Punjabi)

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика. Для вас могут прочесть документы или выслать вам некоторые из них на вашем языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной (ID) карте. Если вам требуется дополнительная помощь, звоните в Департамент страхования штата Калифорния по телефону 1-800-927-4357. (Английский) (Russian)

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter at maipababasa mo sa Tagalog ang mga dokumento. Para makakuha ng tulong, tawagan kami sa numerong nakalista sa iyong ID card. Para sa karagdagang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357 (Taglog)

Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được nhận dịch vụ thông dịch.
Được người khác đọc giúp các tài liệu và một vài tài liệu sẽ được gửi cho quý vị bằng ngôn ngữ của quý vị. Để được giúp đỡ, hãy gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị.
Để được trợ giúp thêm, xin gọi Phòng bảo hiểm California tại số 1-800-927-4357 (Vietnamese)