

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 Disability plans provided by Humana Insurance Company. Dental plans provided by HumanaDental Insurance Company.

Please print clearly and fill in each circle where applicable.

Group number	Benefit number	Class/Division
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Employee information

Last name	First name	MI
<input type="text"/>	<input type="text"/>	<input type="text"/>
Member ID	Employer name	
<input type="text"/>	<input type="text"/>	

Change employee address information

New street address	Apt / Suite / PO box number	
<input type="text"/>	<input type="text"/>	
City	State	Zip code
<input type="text"/>	<input type="text"/>	<input type="text"/>
E-mail address	Phone number	
<input type="text"/>	<input type="text"/>	

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:

- | | | |
|---|---|--|
| <input type="radio"/> Re-hire | <input type="radio"/> Divorce | <input type="radio"/> Dependent birth / adoption |
| <input type="radio"/> Legal separation | <input type="radio"/> Spouse's employer terminates coverage | <input type="radio"/> Other: _____ |
| <input type="radio"/> Employer contribution ceases | <input type="radio"/> Spouse deceased | Qualifying event date (MMDDYYYY) |
| <input type="radio"/> Spouse changes from full-time to part-time employment | <input type="radio"/> Spouse terminates employment | <input type="text"/> |

Change beneficiary

Basic Life

Primary beneficiary name _____ Secondary beneficiary name _____

Voluntary Life

Primary beneficiary name _____ Secondary beneficiary name _____

Agreement **LA-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 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 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 or until the date your coverage terminates, whichever occurs first.

Employee signature:

Date:

Spouse signature:
(If covered dependent)

Date: