

Employee social security number

____ - ____ - _____

Medical

LOUISIANA

- Coverage type:** Employee only
 Employee & spouse
 Family
 Employee & child(ren)
 Other: _____

Office use only

Group # ____	Benefit # ____	Class/Div # ____
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Plan name _____ **Network name** _____

If HMO or POS plan, complete required information in employee & dependent sections

- **Will you or any covered family member have any other medical coverage, such as Medicare or a spouse's medical coverage in effect at the same time as this Humana coverage?** Yes No If yes, list all:

Medicare ID or medical carrier name:

Starting date (MM/DD/YYYY)

____ / ____ / _____

End date, if applicable (MM/DD/YYYY)

____ / ____ / _____

Covered member (check all that apply)

- Employee
- Spouse
- Child(ren)

Medicare ID or medical carrier name:

Starting date (MM/DD/YYYY)

____ / ____ / _____

End date, if applicable (MM/DD/YYYY)

____ / ____ / _____

Covered member (check all that apply)

- Employee
- Spouse
- Child(ren)

- **Besides those listed above, within the last 18 months, have you or any covered family member had any medical coverage, such as Medicare or a spouse's medical coverage?** Yes No If yes, list all: *(This section must be completed for Humana to process any medical claims)*

Prior medical carrier name:

Starting date (MM/DD/YYYY)

____ / ____ / _____

End date, if applicable (MM/DD/YYYY)

____ / ____ / _____

Covered member (check all that apply)

- Employee
- Spouse
- Child(ren)

Prior medical carrier name:

Starting date (MM/DD/YYYY)

____ / ____ / _____

End date, if applicable (MM/DD/YYYY)

____ / ____ / _____

Covered member (check all that apply)

- Employee
- Spouse
- Child(ren)

NOTICE FOR HMO MEMBERS: YOU MUST PERSONALLY BEAR ALL COSTS IF YOU UTILIZE HEALTH CARE NOT AUTHORIZED BY THIS PLAN OR PURCHASE PERScription DRUGS WHICH ARE NOT AUTHORIZED BY THIS PLAN.

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

Employee social security number

____ - ____ - _____

Dental

- Coverage type:** Employee only
 Employee & spouse
 Family
 Employee & child(ren)
 Other: _____

Office use only

Group #	Benefit #	Class/Div #
_____	_____	_____

Plan name _____

• **Within the past 12 months, have you or any covered family member had any dental or orthodontia coverage, such as a spouse's dental coverage?** Yes No If yes, list all: *(This section must be completed for Humana to process any dental claims)*

Current dental carrier name: _____	Orthodontia coverage? <input type="radio"/> Yes <input type="radio"/> No	Starting date (MM/DD/YYYY) ____ / ____ / _____	End date, if applicable (MM/DD/YYYY) ____ / ____ / _____
Covered member (check all that apply) <input type="radio"/> Employee <input type="radio"/> Spouse <input type="radio"/> Child(ren)			

Prior dental carrier name: _____	Orthodontia coverage? <input type="radio"/> Yes <input type="radio"/> No	Starting date (MM/DD/YYYY) ____ / ____ / _____	End date, if applicable (MM/DD/YYYY) ____ / ____ / _____
Covered member (check all that apply) <input type="radio"/> Employee <input type="radio"/> Spouse <input type="radio"/> Child(ren)			

AL-80124-HD 5/2005	AR-80124-HD 5/2005	CO-80124-HD 5/2005	GA-80124-HD	IN-80124-HD 6/2005
KS-80124-HD 3/2005	KY-80124-HD 7/2005	LA-80124-HD 7/2005	MI-80124-HD 7/2005	MS-80124-HD 7/2005
MO-80124-HD 8/2005	NE-80124-HD	NV-80124-HD	NC-80124-HD 8/2005	OH-80124-HD 7/2005
OK-80124-HD	SC-80124-HD	TN-80124-HD	VA-80124-HD	WI-80124-HD 5/2005

Employee social security number

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Health savings account (H.S.A.) *[Applicable only with High Deductible Health Plan selection]*

Do you elect the health savings account?

 Yes No If no, complete waiver section

Effective date of this HSA information

(MM/DD/YYYY)

		/			/				
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How much were you allowed to contribute to any H.S.A.?

For current calendar year-to-date

\$,			.	00
\$,			.	00
\$,			.	00

For second calendar year-to-date,
if plan spans 2 calendar years

\$,			.	00
\$,			.	00
\$,			.	00

How much have you contributed to any H.S.A.?

How much do you wish to contribute to the H.S.A.?

AL-80124-HA	5/2005	AZ-80124-HA	8/2005	AR-80124-HA	5/2005	CA-80124-HA		CO-80124-HA	5/2005
FL-80124-HA		GA-80124-HA		IL-80124-HA	6/2005	IN-80124-HA	6/2005	KS-80124-HA	3/2005
KY-80124-HA	7/2005	LA-80124-HA	7/2005	MI-80124-HA	7/2005	MS-80124-HA	7/2005	MO-80124-HA	8/2005
NE-80124-HA		NV-80124-HA		NC-80124-HA	8/2005	OH-80124-HA	7/2005	OK-80124-HA	
SC-80124-HA		TN-80124-HA		TX-80124-HA	3/2005	VA-80124-HA		WI-80124-HA	5/2005

Flexible spending account (F.S.A.)

Do you elect the flexible health account?

 Yes No If no, complete waiver section

Annual amount elected:

\$, .00

Start date (MM/DD/YYYY)

		/			/				
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End date (MM/DD/YYYY)

		/			/				
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Do you elect the flexible dependent care account?

 Yes No If no, complete waiver section

Annual amount elected:

\$, .00

Start date (MM/DD/YYYY)

		/			/				
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End date (MM/DD/YYYY)

		/			/				
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AL-80124-FS	5/2005	AZ-80124-FS	8/2005	AR-80124-FS	5/2005	CA-80124-FS		CO-80124-FS	5/2005
FL-80124-FS		GA-80124-FS		IL-80124-FS	6/2005	IN-80124-FS	6/2005	KS-80124-FS	3/2005
KY-80124-FS	7/2005	LA-80124-FS	7/2005	MI-80124-FS	7/2005	MS-80124-FS	7/2005	MO-80124-FS	8/2005
NE-80124-FS		NV-80124-FS		NC-80124-FS	8/2005	OH-80124-FS	7/2005	OK-80124-FS	
SC-80124-FS		TN-80124-FS		TX-80124-FS	3/2005	VA-80124-FS		WI-80124-FS	5/2005

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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. 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.

(Check all that apply. Some coverages included in this waiver may not be available in the plan your employer has selected - please see your benefits administrator for more information):

I hereby:

Waive medical for: Myself My spouse My dependent (child)ren
 Waive dental for: Myself My spouse My dependent (child)ren
 Waive basic life for: Myself My spouse My dependent (child)ren
 Waive voluntary life for: Myself My spouse My dependent (child)ren
 Waive short term income protection for: Myself
 Waive health savings account for: Myself
 Waive flexible health account for: Myself
 Waive flexible dependent care account 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
 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 dental or life with any future application for coverage.

AL-80124-WV 5/2005	AZ-80124-WV 8/2005	AR-80124-WV 5/2005	CA-80124-WV	CO-80124-WV 5/2005
FL-80124-WV	GA-80124-WV	IL-80124-WV 6/2005	IN-80124-WV 6/2005	KS-80124-WV 3/2005
KY-80124-WV 7/2005	LA-80124-WV 7/2005	MI-80124-WV 7/2005	MS-80124-WV 7/2005	MO-80124-WV 8/2005
NE-80124-WV	NV-80124-WV	OK-80124-WV	SC-80124-WV	TN-80124-WV
VA-80124-WV	WI-80124-WV 5/2005			

Insuring companies**LOUISIANA**

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.

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 any group coverage

Employee or legal representative signature

Date

		/			/				
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Name and relationship of legal representative _____