



ILLINOIS NON-MEDICAL EMPLOYEE APPLICATION / ENROLLMENT/CHANGE FORM

Group Number

Life and STD plans insured by HUMANA INSURANCE COMPANY formerly Employers Health Insurance Company
Dental PPO and Traditional Preferred plans insured by HumanaDental Insurance Company or HUMANA INSURANCE COMPANY formerly Employers Health Insurance Company
Dental Prepaid plans underwritten by The Dental Concern, Ltd.

Please print using black ink. Attach additional sheets if necessary; sign and date all attachments.

1 Employer Data - Complete with the name and location of the employer company offering benefits.

NAME OF EMPLOYER CITY STATE ZIP CODE

2 Employee Information - Welcome! Please indicate if you are a: [] New Applicant or [] Current Insured/Plan Subscriber

EMPLOYEE/LAST NAME FIRST NAME M.I. SEX SSN BIRTH DATE

EMPLOYEE STREET ADDRESS HOME PHONE () E-MAIL ADDRESS HOME WORK

CITY STATE ZIP HEIGHT FT IN WEIGHT LBS

EMPLOYEE'S OCCUPATION DATE OF FULL-TIME EMPLOYMENT/REHIRE ANNUAL SALARY \$ [] HOURLY [] SALARY

DENTIST NAME* CURRENT PATIENT* Y/N DENTAL NETWORK* FACILITY #*

The following applicants must complete height and weight information: applicants requesting Life insurance over the guaranteed issue amount, and all late enrollees applying for Short Term Disability or Life coverage. * Complete this section if enrolling in a plan that requires the selection of a Dentist. Refer to your Provider Directory.

3 Dependent Information - Please list any dependents to be covered.

Table with 7 columns: NAME/RELATIONSHIP, BIRTH DATE, SEX, HGHT (FT IN), WGHT (LBS), DENTIST NAME*, CURRENT PATIENT*. Rows include SPOUSE and multiple CHILD entries with checkboxes for full-time student status.

4 Plan Selections

Dental Coverage: [] Employee [] Employee & Child(ren) [] Employee & Spouse [] Family

If you have been given a choice of plans, please indicate: Dental Plan _____

Short Term Disability Coverage [] YES [] NO (Amount/Class if Applicable) _____

Basic Life/AD&D (Amount/Class if Applicable) _____

If this coverage is offered by your employer, you will automatically be enrolled upon receipt of this completed form unless in a contributory group you waive this coverage.

Primary Beneficiary name(s) _____

Secondary Beneficiary name(s) _____

Basic Dependent Life: If offered by your employer, and you have enrolled for dependent coverage, your dependents will automatically be enrolled, unless in a contributory group you waive this coverage.

Voluntary Employee Life/AD&D [] YES [] NO Amount _____

Primary Beneficiary name(s) _____

Secondary Beneficiary name(s) _____

Voluntary Dependent Spouse Life/AD&D [] YES [] NO Amount _____ (Available only if Voluntary Employee

Life AD&D is selected) [] YES [] NO

Employee Name _____ Social Security # _____ Group # _____

5 Enrollment Questions

- 1. How many hours per week do you work for this employer? _____ hrs/wk
- 2. Are you or any dependent now disabled or unable to perform normal activities? NO YES
 Name _____ Since what date? _____
 Reason _____
- 3. Within the past 12 months, have you or your dependent(s) had any individual or other group DENTAL coverage?
 NO YES Orthodontia coverage? NO YES
 Dental Carrier Name: _____ Policy Number: _____
 Address: _____ Phone Number: _____
 Effective date: _____ Term date: _____ Still in effect? NO YES
 Who was/is covered on the policy listed above: _____

6 Waiver - Refusal of Coverage

You *must* complete the section below only if you are waiving (declining) any of the coverage available to you through your employer. Please note, Employee can only waive Basic Life/AD&D and Short-Term Disability if plan is contributory. **This is to acknowledge that I have been given opportunity to apply for group coverage available to me and my dependents pursuant to state law through the above named employer. I hereby waive insurance coverage for:**

Myself: Dental Voluntary Life/AD&D Basic Life/AD&D Short Term Disability

My Spouse: Dental Voluntary Life/AD&D Basic Dependent Life

Dependent Children: Dental Voluntary Life Basic Dependent Life

I decline to apply for group coverage because of: Spousal coverage Other _____

I proclaim that I was not pressured or forced by the employer named above, the writing agent, or Humana Insurance Company, HumanaDental Insurance Company or Humana into waiving (declining) the above noted coverage. I understand that 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) which may require additional limitations and waiting periods. I also understand that I may be required to furnish, at my own expense, evidence of health status satisfactory to Humana Insurance Company, HumanaDental Insurance Company or Humana. I understand that Humana Insurance Company, HumanaDental Insurance Company and Humana reserves the right to deny coverage with any future application for coverage. I freely and voluntarily waive the above noted coverage.

Date _____ **Employee Signature X** _____

7 Agreement

I hereby acknowledge that I have read the above statements or that they have been read to me. I declare and agree that the answers are, to the best of my knowledge and belief, complete and true and, together with any supplements thereto, shall be the basis for any certificate of coverage/certificate of insurance issued. I understand and agree that neither the employer nor the agent has the authority to waive a complete answer to any question, pass on insurability, alter any contract, or waive any of the company's other rights or requirements. **I hereby agree that no insurance will be effective until the date specified by the company on the certificate of coverage/certificate of insurance after this application has been accepted.** I understand that any misrepresentation contained herein relied on by the Company may be used to reduce or deny a claim or void the contract within the contestable period if such misrepresentation materially affects the acceptance of the risk.

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. An Enrollment Form should not be submitted more than 60 days prior to the effective date. This document will become a part of the certificate if coverage is approved.

Date _____ **Employee Signature X** _____

8 Evidence of Health Status - Please provide details to any "Yes" answers in the space provided below.

Complete this section for Applicants requesting Life insurance over the guarantee issue amount, and all late enrollees applying for Short Term Disability or Life coverage.

	Yes	No
1. Are you or any dependent currently under any treatment or prescribed medications?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you or any dependent had unexplained weight loss or fatigue in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you or any dependent ever had, been diagnosed with, counseled, consulted, or treated for any of the following:		
A. Chest pain; disease of heart, arteries or blood vessels; high or low blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
B. Nervous, mental or emotional disorder; convulsions; epilepsy; unconsciousness?	<input type="checkbox"/>	<input type="checkbox"/>
C. Asthma or other disease of lungs or respiratory organs?	<input type="checkbox"/>	<input type="checkbox"/>
D. Kidney stones; disease of the kidney, bladder, male or female organs; or infertility?	<input type="checkbox"/>	<input type="checkbox"/>
E. Cancer, and/or cancerous tumor? (state type; part of body)	<input type="checkbox"/>	<input type="checkbox"/>
F. Diabetes; liver or thyroid disease; or enlargement of the lymph nodes?	<input type="checkbox"/>	<input type="checkbox"/>
G. Stomach, gall bladder, intestinal or colon disorders?	<input type="checkbox"/>	<input type="checkbox"/>
H. Rheumatoid arthritis or back disorders?	<input type="checkbox"/>	<input type="checkbox"/>
I. Phlebitis, paralysis, or any other physical impairment or deformity?	<input type="checkbox"/>	<input type="checkbox"/>
J. Alcoholism or drug habit, or been a member of Alcoholics Anonymous?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you or any dependent been diagnosed or received treatment for AIDS or an AIDS-related complex or other immune system disorder within the past 5 years?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you or any dependent been hospitalized or had hospitalization advised, had surgery or been advised to have surgery, had any injury, illness, medical attention or medical advice or treatment during the past 5 years for any reason not already mentioned?	<input type="checkbox"/>	<input type="checkbox"/>

Please give details to "yes" answers from questions above (specify question number). Attach additional signed & dated sheets if necessary.

No.	PERSON TREATED	ILLNESS OR IMPAIRMENT & MEDICATION (IF ANY)	DATES TREATED	NAME/ADDRESS OF PHYSICIAN AND/OR HOSPITAL

Agreement

I hereby acknowledge that I have read the above statements or that they have been read to me. I declare and agree that the answers are, to the best of my knowledge and belief, complete and true and, together with any supplements thereto, shall be the basis for any certificate of coverage/certificate of insurance issued. I understand and agree that neither the employer nor the agent has the authority to waive a complete answer to any question, pass on insurability, alter any contract, or waive any of the company's other rights or requirements. **I hereby agree that no insurance will be effective until the date specified by the company on the certificate of coverage/certificate of insurance after this application has been accepted.** I understand that any misrepresentation contained herein relied on by the Company may be used to reduce or deny a claim or void the contract within the contestable period if such misrepresentation materially affects the acceptance of the risk.

Authorization: I authorize any physician, medical practitioner, hospital, clinic, veterans administration facility, other medical or medically-related facility, insurance, HMO or reinsuring company, the Medical Information Bureau, Inc., or Consumer Reporting Agency having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or my covered dependents, and any other non-medical information of me or my covered dependents to give to Humana Insurance Company or Humana or their legal representative any and all such information.

I understand the information obtained by use of the authorization may be used by Humana Insurance Company or Humana to determine eligibility for coverage and eligibility for benefits under an existing policy. Any information obtained will not be released by the insurer or health maintenance organization to any person or organization except to reinsuring companies, the Medical Information Bureau, Inc. or other persons or organizations performing business or legal services in connection with any application, claim or as may be otherwise lawfully required, or as I may further authorize. I know that I may request to receive a copy of this authorization. I agree that a photographic copy of this authorization shall be as valid as the original. I agree that this authorization shall be valid for two years from the date shown below.

Date _____ Employee Signature X _____

Date _____ Spouse's Signature X _____ (if dependent coverage)