Print Form

Visit us at www.humana.com or www.humanadental.com

Humana Employee Enrollment Application - Dental and Vision MASSACHUSETTS

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

Vision plans insured and administered by Humana Insurance Company.
Dental plans insured or administered by HumanaDental Insurance Company. Dental Discount plans offered by CompBenefits Direct, Inc.

Please print clearly and fill in each applicable circle.

Proposed effective date: _ _ / _ _ / _ _ _ _

Company name Dighton Rehoboth Regional	Company city	State

Enrollment Information

Relationship	Last name, First name MI	Height (ft / in)	Weight (lbs.)	Gender	Full-time student?	Date of birth	Disabled? If yes, indicate reason.
Employee		/		❍ F ❍ M	N/A	_ _ / _ _ / _ _ _ _	❍ N ❍ Y Reason:
Spouse		/		❍ F ❍ M	N/A	_ _ / _ _ / _ _ _ _	❍ N ❍ Y Reason:
Child		/		❍ F ❍ M	❍ N ❍ Y	_ _ / _ _ / _ _ _ _	❍ N ❍ Y Reason:
Child		/		❍ F ❍ M	❍ N ❍ Y	_ _ / _ _ / _ _ _ _	❍ N ❍ Y Reason:
Child		/		❍ F ❍ M	❍ N ❍ Y	_ _ / _ _ / _ _ _ _	❍ N ❍ Y Reason:
Other (specify):		/		❍ F ❍ M	❍ N ❍ Y	_ _ / _ _ / _ _ _ _	❍ N ❍ Y Reason:

EMPLOYEE INFORMATION: **HOURS WORKED PER WEEK:** ❍ **RETIREE** **DATE OF FULL-TIME HIRE:** _ _ / _ _ / _ _ _ _

SSN #	Street address	APT / Suite / Box
City	State / Zip code	Phone # ( )
Language: ❍ English ❍ Spanish	Email address	

~~Dental~~

Group #: | Benefit #: | Class/Div:

~~Coverage type:~~ ❍ ~~Employee only~~ ❍ ~~Employee and spouse~~ ❍ ~~Employee and child(ren)~~ ❍ ~~Family~~ ❍ ~~NO COVERAGE (complete waiver)~~ — ~~Plan name~~

~~Prior dental coverage during the past 12 months (individual or other group coverage)?~~ ❍ ~~N~~ ❍ ~~Y~~

~~Prior dental insurance carrier name~~	~~**Prior coverage type:**~~ ❍ ~~Employee only~~ ❍ ~~Employee and spouse~~ ❍ ~~Employee and child(ren)~~ ❍ ~~Family~~	~~Effective date~~ _ _ / _ _ / _ _ _ _	~~Policy #~~
~~Prior orthodontia coverage in the past 12 months?~~ ❍ ~~N~~ ❍ ~~Y~~		~~Term date~~ _ _ / _ _ / _ _ _ _	~~Prior carrier phone # ( )~~

Vision

Group #: 571174 | Benefit #: | Class/Div:

Coverage type: ❍ Employee only ❍ Employee and spouse ❍ Employee and child(ren) ❍ Family ❍ NO COVERAGE (complete waiver) — Plan name

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 is evidence of this action.

I hereby waive coverage for (check all that apply):	I decline to apply for group coverage because of:
Dental for: ❍ Myself ❍ My spouse ❍ My dependent child(ren) Vision for: ❍ Myself ❍ My spouse ❍ My dependent child(ren)	❍ Spousal coverage ❍ Medicare supplement ❍ Individual coverage ❍ Coverage under another carrier's plan provided by my employer ❍ Other:

Last name: First name:

Notice of Information Practices

Humana may collect personal information about you and your family when you complete applications and forms. We also collect information from your dealings with us, our affiliates or others. We may share personal or privileged information with affiliated companies and non-affiliated third parties without authorization, as permitted by law. You have the right to review and obtain a copy of your information that may be used to make decisions about you. You also have the right to request an amendment of information we maintain about you if you believe the information is wrong or incomplete. A complete notice of our privacy practices can be obtained by contacting us at 1-866-861-2762 or by visiting our website at www.humana.com and going to the privacy practices link.

Disclosures (applicable to dental and vision plans)

Pre-existing conditions are not excluded. Benefits listed in the policy/certificate ARE NOT contingent upon hospital confinement. Coverage for You and/or Your Dependent may be canceled or its renewal refused because of:

1. failure to pay the required premium;
2. misrepresentation or fraud on the part of the member;
3. commission of acts of physical or verbal abuse by the member which pose a threat to providers or other members and which are unrelated to the physical or mental condition of the member; or
4. non-renewal or cancellation of the Policy through which the member receives services.

If Your coverage ends because of (1) above, We will send written notice of the termination to You prior to the date covered services were received. The written notice will contain the following information:

1. the date on which the plan was terminated;
2. that the termination was for failure to pay the required premium; and
3. that We will honor claims, to the extent covered under the Policy, for any covered service received by You or Your Dependent prior to the notification date.

If Your coverage ends it will not prejudice any existing claim. If service is being rendered at the time coverage ends for an Insured, We will continue to reimburse for such service to completion, but in no event beyond a 3-month period following the date coverage ended.

I acknowledge that I have read and understand the above disclosures.

Employee or legal representative signature: _____ Date: _____

Name and relationship of legal representative: _____

Agreement

True and complete acknowledgement

I understand, agree and represent:

- I have read this document or it has been read to me and answers provided are true and complete to the best of my knowledge and belief.
- Neither my employer nor the agent can waive 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. If I have a new dependent as a result of a qualifying event, I may in the future be able to enroll myself or my dependents provided I request enrollment within 31 days after the qualifying event.
- In the event that I should decide to apply for coverage hereafter, that subsequent application shall be subject to the applicable terms and conditions of the master group contract(s) or plan provisions 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.
- Humana reserves the right to deny life or dental coverage with any future application for coverage.
- Any misrepresentation contained herein relied on by Humana may be used to reduce or deny a claims or void the contract within the contestable period if such misrepresentation materially affected the acceptance of the risk.

Signature - please sign below if enrolling or waiving group coverage.

If you decide not to sign this authorization, Humana cannot complete your plan enrollment or determine your premium rate due to the inability to obtain the necessary information.

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.)