Small Group Employee Application and Enrollment Form - 1-50 Employees **TEXAS**

You have the option to choose this Consumer Choice of Benefits Health Maintenance Organization health care plan that, either in whole or in part, does not provide state-mandated health benefits normally required in evidences of coverage in Texas. This standard health benefit plan may provide a more affordable health plan for you although, at the same time, it may provide you with fewer health plan benefits than those normally included as state-mandated health benefits in Texas. If you choose this standard health benefit plan, please consult with your insurance agent to discover which state-mandated health benefits are excluded in this evidence of coverage.

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in the Small Group Employee Application and Enrollment Form as "Humana". To elect primary care physician, dentist or OBGYN, please complete the Humana Employee Primary Care Physician/Dentist Selection section at the end of this application.

PPO and Indemnity Medical plans and Life plans insured or administered by Humana Insurance Company. HMO plans offered by Humana Health Plan of Texas, Inc., a Health Maintenance Organization. POS plans offered by Humana Health Plan of Texas, Inc., a Health Maintenance Organization and insured or administered by Humana Insurance Company. Prepaid dental benefits offered and administered by DentiCare, Inc. (d/b/a CompBenefits). All other Dental plans insured or administered by HumanaDental Insurance Company or Humana Insurance Company. Vision plans insured and administered by HumanaDental Insurance Company or Humana Insurance Company. Short Term Disability, Long Term Disability and Workplace Voluntary Benefits plans insured or administered by Kanawha Insurance Company.

Please print clearly and fill in each applicable circle. Proposed effective date: __/__/____

Employer / Group name	Employer / Group city	State

Qualifying Event Instructions Date of Qualifying Event: __/__/____

❍ New business enrollment ❍ Open Enrollment event ❍ Dependent birth or adoption ❍ Loss of coverage
❍ New hire / Newly eligible ❍ Rehire / Reinstatement ❍ Marital status change ❍ Other_____

Enrollment information

Relationship	Last name, First name MI	Gender	Date of birth	Disabled? If yes, indicate reason below.		Social Security Number
Employee / Individual		❍ F ❍ M	__/__/____	❍ Y ❍ N		N/A (complete in Employee/ Individual Information section.)
Spouse / Domestic Partner		❍ F ❍ M	__/__/____	❍ Y ❍ N		
Child / Dependent		❍ F ❍ M	__/__/____	❍ Y ❍ N		
Child / Dependent		❍ F ❍ M	__/__/____	❍ Y ❍ N		
Child / Dependent		❍ F ❍ M	__/__/____	❍ Y ❍ N		
Other (specify):		❍ F ❍ M	__/__/____	❍ Y ❍ N		

Employee / Individual Information

Hours worked per week:		Date of full time hire: __/__/____	
Social Security Number	Street address		APT / Suite / Box
City	State	ZIP code	Phone # ( )
Language: ❍ English ❍ Spanish ❍ Other	E-mail address	Occupation	
Do you have a disability that affects your ability to communicate or read? ❍ N ❍ Y			
Are you actively at work? ❍ Y ❍ N If not, reason: ❍ Retiree ❍ COBRA/State Continuation Other: _____			Annual salary $

Prior / Existing Coverage: **IMPORTANT - DO NOT** cancel any existing coverage until you receive written notification from Humana of your acceptance for coverage.

Medical

1. Prior medical coverage during the past 18 months (individual or other group coverage)? ❍ N ❍ Y

Prior medical insurance carrier name	Policy #	Prior coverage type: ❍ Employee / Individual only ❍ Employee / Individual and spouse ❍ Employee / Individual and child(ren) ❍ Family	Effective date __/__/____
			Term date __/__/____

Last name:	First name:

2. Other medical coverage in effect at the same time as this Humana coverage (individual or other group coverage)? ❍ N ❍ Y

Other medical insurance carrier name	Policy #	Other coverage type: ❍ Employee / Individual only ❍ Employee / Individual and spouse ❍ Employee / Individual and child(ren) ❍ Family	Effective date __/__/____ Term date __/__/____

3. Medicare

Employee / Individual coverage: ❍ N ❍ Y	Medicare ID	Effective date __/__/____	Term date __/__/____
Spouse coverage: ❍ N ❍ Y	Medicare ID	Effective date __/__/____	Term date __/__/____

Dental

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

2. Prior orthodontia coverage in the past 12 months? ❍ N ❍ Y

Prior dental insurance carrier name	Policy #	Prior coverage type: ❍ Employee / Individual only ❍ Employee / Individual and spouse ❍ Employee / Individual and child(ren) ❍ Family
	Effective date __/__/____	
Prior carrier phone # ( )	Term date __/__/____	

Coverage Options

Medical Group #: Benefit #: Class/Div:

Coverage type: ❍ Employee / Individual only ❍ Employee / Individual and spouse ❍ Employee / Individual and child(ren) ❍ Family ❍ No Coverage (complete waiver)

Plan name:

Health Savings Account Group #: Benefit #: Class/Div:

If you have medical coverage under another plan, you may not be eligible for an HSA. Please check with your tax advisor for details. Please refer to Humana's HSA contribution worksheet to calculate your maximum allowed contribution. You can find additional information on HSAs on Humana.com. Select the Quick Link for Spending Account information on the Member page.

Do you elect the Health Savings Account? ❍ N ❍ Y (If no, complete waiver.)

Beneficiary for this account will be the employees / individual's estate. You may change beneficiary information on file with the bank that administers the HSA once the account is established.

Dental Group #: Benefit #: Class/Div:

Coverage type: ❍ Employee / Individual only ❍ Employee / Individual and spouse ❍ Employee / Individual and child(ren) ❍ Family ❍ No Coverage (complete waiver)

Rate Amount $_____ Rate Frequency (Monthly)
Rate Amount $_____ Rate Frequency (Monthly)
Rate Amount $_____ Rate Frequency (Monthly)
Rate Amount $_____ Rate Frequency (Monthly)

Plan name:

Basic Life AD&D Group #: Benefit #: Class/Div:

Basic dependent life ❍ N ❍ Y (If no, complete waiver.)

Class (employer will provide you with this information, if needed)

Voluntary Life AD&D Group #: Benefit #: Class/Div:

Voluntary employees / individual life coverage ❍ N ❍ Y

Amount (min $15,000) $

Voluntary spouse life coverage? ❍ N ❍ Y

Amount (min $5,000) $

Voluntary child(ren) life coverage? ❍ N ❍ Y

Vision Group #: Benefit #: Class/Div:

Coverage type: ❍ Employee / Individual only ❍ Employee / Individual and spouse ❍ Employee / Individual and child(ren) ❍ Family ❍ No Coverage (complete waiver)

Rate Amount $_____ Rate Frequency (Monthly)
Rate Amount $_____ Rate Frequency (Monthly)
Rate Amount $_____ Rate Frequency (Monthly)
Rate Amount $_____ Rate Frequency (Monthly)

Plan name:

Short Term Disability Group #: Benefit #: Class: Div:

Short Term Disability ❍ N ❍ Y (If no, complete waiver.) Buy-up percent/amount _____

Long Term Disability Group #: Benefit #: Class: Div:

Long Term Disability ❍ N ❍ Y (If no, complete waiver.) Buy-up percent/amount _____

Last name: | First name:

Workplace Voluntary Benefits: Optional riders availability based on employer / group election.

Accident - 2012 **Group #:** **Benefit #:** **Class:** **Div:**

❍ Accident ❍ N ❍ Y Benefit Level: ❍ 1 ❍ 2 ❍ 3 ❍ 4

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

Disability Income Plus **Group #:** **Benefit #:** **Class:** **Div:**

❍ Disability Income Covering Accident and Sickness ❍ N ❍ Y
Base Benefit Period: ❍ 3 Month ❍ 6 Month ❍ 1 Year ❍ 2 Year ❍ 3 Year
Base Elimination Period: ❍ 0/7 ❍ 7/7 ❍ 0/14 ❍ 14/14 ❍ 30/30 ❍ 60/60 ❍ 90/90 ❍ 180/180 ❍ 365/365

Monthly Benefit $

❍ Disability Income Covering Accident and Sickness with Waiver of Elimination Period ❍ N ❍ Y
Base Benefit Period: ❍ 3 Month ❍ 6 Month ❍ 1 Year ❍ 2 Year ❍ 3 Year
Base Elimination Period: ❍ 0/7 ❍ 7/7 ❍ 0/14 ❍ 14/14

Optional Disability Income Benefits: ❍ ICU / CCU Benefit ❍ $200 ❍ $400 ❍ $600 ❍ $800
❍ Physical Therapy Benefit ❍ COBRA Rider | COBRA Monthly Benefit $

Level Term Life **Group #:** **Benefit #:** **Class:** **Div:**

❍ Level Term Life / AD&D ❍ N ❍ Y | Coverage type: ❍ Employee / Individual only ❍ Spouse ❍ Child(ren) | Base Plan: ❍ 10-Year Term ❍ 20-Year Term Optional Benefit: ❍ Automatic Benefit Increase

Employee / Individual Benefit $ | Spouse Benefit $ | Child(ren) Benefit $

If your employer or group has elected the critical illness rider, have you or any dependent had a parent, brother, or sister with a history of heart attack, heart disease, stroke, or cancer diagnosis prior to age 60 ? ❍ N ❍ Y If yes, please indicate whether this applies to you (Employee / Individual), your spouse or a dependent.
❍ You (Employee / Individual) ❍ Spouse ❍ Dependent Name_____

Critical Illness **Group #:** **Benefit #:** **Class:** **Div:**

❍ Critical Illness ❍ N ❍ Y
❍ Critical Illness and Cancer ❍ N ❍ Y | Coverage type: ❍ Employee / Individual only ❍ Employee / Individual and spouse ❍ Employee / Individual and child(ren) ❍ Family

Optional Benefits: ❍ Automatic Benefit Increase ❍ Health Screening | Employee / Individual Benefit $

Does anyone on this application have a parent, brother, or sister with a history of heart attack, heart disease, stroke, or cancer diagnosis prior to age 60? ❍ N ❍ Y If yes, please indicate whether this applies to you (Employee / Individual), your spouse or a dependent. ❍ You (Employee / Individual) ❍ Spouse ❍ Dependent Name_____

Group Lump Sum Cancer **Group #:** **Benefit #:** **Class:** **Div:**

❍ Group Lump Sum Cancer ❍ N ❍ Y | Coverage type: ❍ Employee / Individual only ❍ Employee / Individual and spouse ❍ Employee / Individual and child(ren) ❍ Family

Does anyone on this application have a parent, brother, or sister with a history of cancer diagnosis prior to age 60 ? ❍ N ❍ Y
If yes, please indicate whether this applies to you (Employee / Individual), your spouse or a dependent.
❍ You (Employee / Individual) ❍ Spouse ❍ Dependent Name_____

Rider: ❍ Automatic Benefit Increase ❍ Health Screenings Base Benefit $

Hospital Indemnity **Group #:** **Benefit #:** **Class:** **Div:**

❍ Hospital Indemnity ❍ N ❍ Y | Coverage type: ❍ Employee / Individual only ❍ Employee / Individual and spouse ❍ Employee / Individual and child(ren) ❍ Family

Plan type: ❍ 1 ❍ 2 ❍ 3 ❍ 4

If your employer or group has elected the critical illness benefit, does anyone on this application have a parent, brother, or sister with a history of heart attack, heart disease, stroke, or cancer diagnosis prior to age 60? ❍ N ❍ Y If yes, please indicate whether this applies to you (Employee / Individual), your spouse or a dependent.
❍ You (Employee / Individual) ❍ Spouse ❍ Dependent Name_____

Beneficiary Information for Life, Disability and Workplace Voluntary Benefits

Primary beneficiary name (Last, First MI)	Relationship to Employee / Individual
Secondary beneficiary name (Last, First MI)	Relationship to Employee / Individual

Last name:	First name:

Evidence of Health Status - Do not submit more than 90 days prior to the effective date.

Complete this section if you are selecting workplace voluntary (excludes Accident) benefits and/or Life over the guarantee issue amount.

1.	Is anyone on this application currently taking any prescribed medication, or do you periodically take medication for a recurrent condition?	❍ N ❍ Y
2a.	In the past 12 months has any applicant used any tobacco product? If yes, applies to: ❍ Employee ❍ Spouse/Domestic Partner❍ Other ❍ Child/Dependent	❍ N ❍ Y
2b.	Is any applicant currently a smoker? If yes, applies to: ❍ Employee ❍ Spouse/Domestic Partner❍ Other ❍ Child/Dependent	❍ N ❍ Y
3.	In the past 12 months, have you missed 5 or more consecutive days of work due to an injury or illness other than as a result of a cold, the flu, back problems, strained/sprained/fractured/broken limb or as a result of pregnancy?	❍ N ❍ Y
4.	Has anyone on this application had a positive diagnosis or received treatment by a medical practitioner for an immune system disorder (i.e. Lupus, ITP), AIDS or an AIDS-related complex?	❍ N ❍ Y
5.	Within the past 5 years, has anyone on this application been diagnosed with diseases or disorders related to, counseled, consulted, or treated by a doctor, including surgery, for any of the following:	

a.	Coronary artery disease, chest pain, heart surgery, or any disease of the arteries, or blood disorders; anemia; hemophilia; phlebitis; high blood pressure (reading higher than 140/90)?	❍ N ❍ Y
b.	Nervous, mental or emotional disorder; convulsions; epilepsy; unconsciousness; Multiple Sclerosis; Parkinson's Disease; Cerebral Palsy?	❍ N ❍ Y
c.	Stroke; Transient Ischemic Attack (TIA)?	❍ N ❍ Y
d.	Emphysema; asthma, or other disease of lungs, or respiratory organs?	❍ N ❍ Y
e.	End stage renal disease; disease of kidney?	❍ N ❍ Y
f.	Kidney stones; bladder?	❍ N ❍ Y
g.	Male or female organs; or infertility?	❍ N ❍ Y
h.	Cancer, and/or cancerous tumor; including skin cancer?	❍ N ❍ Y

i.	Diabetes; liver or thyroid disease; hepatitis; cirrhosis; or enlargement of the lymph nodes?	❍ N ❍ Y
j.	Stomach, gall bladder, digestive, intestinal, or colon disorders?	❍ N ❍ Y
k.	Rheumatoid arthritis; or back disorders; or joint disorders?	❍ N ❍ Y
l.	Paralysis, or any other physical impairment or deformity?	❍ N ❍ Y
m.	Chronic Fatigue Syndrome/Fibromyalgia?	❍ N ❍ Y
n.	Diseases of the eye, ear, nose, or throat? Disease or disorder which has led or may lead to a permanent or progressive loss of vision, hearing or speech?	❍ N ❍ Y
o.	Alcoholism or drug habit?	❍ N ❍ Y

6.	Has anyone on this application been advised by a member of the medical profession to have any diagnostic test, hospitalization, or surgery that has not been completed within the past 5 years?	❍ N ❍ Y
7.	Within the past 5 years, has anyone on this application seen a health care provider or specialist for a routine physical/wellness exam, or been seen for any reason not previously disclosed?	❍ N ❍ Y
8.	Is anyone on this application currently pregnant? If yes, please indicate anticipated delivery date below. Anticipated delivery date:_____	❍ N ❍ Y
9.	**Hospital Indemnity only:** Can you perform your activities of daily living (ADL's) without need of assistance? ADL's include: Bathing, Transferring, Feeding, Dressing and Bowl/Bladder/Toileting.	❍ N ❍ Y

Relationship	Last name, First name MI	Height (ft / in)	Weight (lbs)
Employee		/	
Spouse / Domestic Partner		/	
Child / Dependent		/	
Child / Dependent		/	
Child / Dependent		/	
Other (specify):		/	

Last name:	First name:

If you answered "yes" to any of the questions above, please provide details below and specify the question number. Attach additional signed and dated sheets (reorder TX-51340-MH), if necessary.

Question #	Person treated (Last name, First name)
Condition	Treatments received
Medications prescribed	Current or future treatments or medications
Date diagnosed _ _ / _ _ / _ _ _ _	Date last seen by a doctor _ _ / _ _ / _ _ _ _

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 / group. I proclaim that I was not pressured or forced by my employer / group, 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):

Medical for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Dental for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Basic Life for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Vision for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Short Term Disability for:	❍ Myself		
Long Term Disability for:	❍ Myself		
Health Savings Account for:	❍ Myself		

Waive Coverage for Workplace Voluntary Benefits:

Level Term Life for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Critical Illness for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Group Lump Sum Cancer for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Acciden t for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Hospital Indemnity for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Disability Income Plus 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 / group
- ❍ Other:_____

Agreement

True and complete acknowledgement

I understand, agree, and represent:

- I have read the Small Group Employee Application and Enrollment Form 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 / group 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 the Small Group Employee Application and Enrollment Form for coverage is accepted, coverage will be effective on the date specified by Humana on the policy or certificate.
- 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.
- If I or my dependents become eligible for premium or rate subsidies under Medicaid or the Children's Health Insurance Program (CHIP), I may in the future be able to enroll myself or my dependents provided I request enrollment within 60 days after the qualifying event.
- In the event that I should decide to apply for coverage hereafter, that subsequent Small Group Employee Application and Enrollment Form shall be subject to the applicable terms and conditions of the master group contract(s), policy provisions or certificate provisions which may require additional limitations and waiting periods.
- Based on the coverage I have elected, I may be required to furnish evidence of health status satisfactory to Humana. This information will be used only for rating and administrative purposes and not for purposes of eligibility for coverage.
- If I am declining coverage for myself or my dependents (including my spouse) because of coverage under Medicaid or CHIP, I may in the future be able to enroll myself or my dependents provided that I request enrollment within 60 days after my coverage under these programs ends.
- 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 any deductions are required for this coverage, I authorize those deductions from my earnings. If selecting the Health Savings Account (HSA), I authorize Humana or its banking partners to provide my account number to my employer / group for the purposes of depositing any contributions.
- If I am applying for coverage for my dependents (including my spouse) I attest by my signature below, I have gathered the necessary health information from my dependents in order to fully and truthfully complete the Small Group Employee Application and Enrollment Form.
- If I have selected workplace voluntary benefits, and if coverage is not issued as initially applied for, I hereby authorize Humana to decrease or increase the premium or rate amount stated on the Small Group Employee Application and Enrollment Form to cover the benefit actually issued.

Last name:	First name:

- An act of fraud or an intentional misrepresentation of a material fact may void or terminate an individual's or group's coverage as specified under the terms of the Policy or Certificate. Providing incomplete, inaccurate, or untimely information may reduce an individual's or group's coverage or may increase past premium.
- Rates or premium quoted and the effective date requested are not guaranteed. The final rate or premium and effective date will be determined upon underwriting review and approval of the Small Group Employee Application and Enrollment Form by Humana.
- For small employer groups, I understand that any misstatements of health status will not be used to cancel, non-renew or void my medical coverage under this policy or plan but may result in an increase in medical premiums following a written notice as required in the Policy or Group Contract.
- Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of fraud.

If you decide not to sign this agreement, we will decline to enroll you in an insurance product or to give you insurance benefits.

Authorization

My dependents and I understand and agree:

- The information obtained by use of this authorization may be used by Humana to make claims determinations, 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 the Group Employee Application and Enrollment Form, claim or as may be otherwise lawfully required, or as I (we) may further authorize.

Authorization for Release of Medical Records for Life or Disability

If my dependents or I have selected life or disability, I authorize any third party to have information regarding myself. This includes any medical or non-medical information and to share any and all such information with Humana, its reinsurer or its legal representatives, and its affiliates. Once personal and health (including medical, dental, and pharmacy) information is disclosed pursuant to this authorization, the recipient may redisclose it and the information may not be protected by federal and state privacy requirements.

The Small Group Employee Application and Enrollment Form, together with any supplemental forms, will make up part of any contract and be the basis for any policy or certificate.

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 / Individual or legal representative signature: _____ Date: _____

Name and relationship of legal representative: _____

Spouse signature: _____ Date:_____
(Only if selecting Life coverage over the guarantee issue amount.)

Required Disclosure Notice for POS & HMO Consumer Choice Benefit Plans

Below is the Required Disclosure Notice for Group POS & HMO Consumer Choice Benefit Plans Issued in Texas. To obtain a copy of the required Consumer Choice Disclosure Notice for Consumer Choice Benefit Plans Issued in Texas, please consult your insurance agent.

If your employer has selected the Consumer Choice HMO Benefits Health Plan or the Consumer Choice POS Benefits Health Plan, your plan in whole or in part does not provide state-mandated health benefits normally required in Texas health benefit plans.

A consumer choice standard health benefit plan may provide more affordable health benefits for you although, at the same time, it may provide you with fewer health benefits than those normally included as state-mandated health benefits in Texas health benefit plans. Please consult with your Benefit Administrator to discuss the state-mandated health benefits that are reduced and/or excluded.

Excluded POS State Mandates	**Excluded HMO State Mandates**
Invitro	Invitro

The Consumer Choice Health Benefit Plan may include requirements and/or restrictions on deductibles, coinsurance, copayments, or maximum benefit amounts that differ from other POS & HMO plans. I understand that I may obtain from the Department of Insurance a consumer brochure with more information on Consumer Choice Health Benefit Plans, either by visiting the TDI website at www.tdi.texas.gov/consumer/index.html, or by calling 1-800-252-3439.

By signing this application, I acknowledge that I was offered the opportunity to apply for an accident and sickness insurance policy or evidence of coverage in the same category that most closely approximates the consumer choice health benefit plan offered.

Last name:	First name:

Agent / Producer Information

If applying for workplace voluntary benefits, this section to be completed by Agent or Producer.

1. Agent / Agency of Record:	**2. Agent / Agency of Record:**
Name (print)	Name (print)
Humana Agent #	Humana Agent #
Commission split:	Commission split:
1. Writing Agent / Producer:	**2. Writing Agent / Producer:**
Name (print)	Name (print)
Humana Agent #	Humana Agent #
Commission split:	Commission split:

Will the coverage selected replace or change any existing life or disability insurance policy(s) and/or annuity(s)? ❍ N ❍ Y

As the Writing Agent / Producer, I acknowledge that I am responsible to meet with the primary applicant submitting the Small Group Employee Application and Enrollment Form in order to fully and accurately represent the terms and conditions of the plans and services of the offering or insuring entity, or one of its subsidiaries including an explanation of the Consumer Choice Benefit Plans. These provisions are available to me and the primary applicant in the benefit summary document or other plan literature.

Signed at _____ _____
County State

Writing Agent's Signature _____ Date __ __/__ __/__ __ __ __

The original version of this Agreement is in the English language. If there are any discrepancies or conflicts between the English and any other version that has been translated into another language, the English version will control.

Last name:	First name:

Humana Employee Primary Care Physician/Dentist Selection (for HMO/DHMO use only)

In addition to a primary care physician, you may select an OB/GYN to provide obstetrical or gynecological services. You are not required to select an OB/GYN, but may instead receive obstetrical or gynecological services from your primary care physician.

Please print clearly and fill in each applicable circle.

Primary Care Physician Selection (for HMO use only)

	Member Last name First name MI	Primary care physician name	Physician ID	Current patient
Employee				❍ N ❍ Y
Spouse				❍ N ❍ Y
Child				❍ N ❍ Y
Child				❍ N ❍ Y
Child				❍ N ❍ Y
Other (specify)				❍ N ❍ Y

Primary Dentist Selection (for DHMO use only)

	Member Last name First name MI	Primary dentist name	Dentist ID	Current patient
Employee				❍ N ❍ Y
Spouse				❍ N ❍ Y
Child				❍ N ❍ Y
Child				❍ N ❍ Y
Child				❍ N ❍ Y
Other (specify)				❍ N ❍ Y

OBGYN Primary Care Physician Selection (for HMO use only)

Relationship	Member Last name, First name MI	Primary care OBGYN physician name	Physician ID	Current patient?
Employee				❍ N ❍ Y
Spouse				❍ N ❍ Y
Child				❍ N ❍ Y
Child				❍ N ❍ Y
Child				❍ N ❍ Y
Other (specify):				❍ N ❍ Y