Humana Inc. Life Insurance Enrollment/Underwriting Form

Associate Information

Name _____Social Security Number _____

Associate ID number _____ Date of Birth ___/___/___ Date of Hire ___/___/___ Gender: (circle) M or F

Address _____

Work Phone Number _____ Home Phone Number _____

E-Mail Address _____

Voluntary Term Life Insurance

Associate: Maximum coverage is 6 times salary or $500,000, whichever is less. Spouse: Maximum is 50% of associate's coverage up to $250,000. Dependent and Spouse coverage are available only if the associate is also covered for Voluntary Term Life/AD&D

Effective date ___/___/___

Please indicate below the total amount of coverage you requested online. If there is a discrepancy between this form and your online enrollment, the requested amount online will prevail.

Associate $_____ Spouse $_____

Spouse/Domestic Partner's Name _____ Spouse/Domestic Partner's Date of Birth ___/___/___

Dependent Child(ren) _____$10,000

I understand that any increase in my or my dependent's coverage is subject to approval by the Insurance Company. I also understand that I am responsible to report to the Insurance Company any change in my health prior to the effective date of my or my dependents' increase in coverage.
I authorize my employer to deduct the Voluntary Term Life premiums from my earnings.

Signature of associate X_____Date _____

Signature of Spouse/Domestic Partner X_____Date _____
(Only required if requesting additional Spousal coverage)

This original, signed copy and accompanying underwriting form(s) must be forwarded to the following address for processing:

Humana Life Insurance
Underwriting Team Six
1100 Employers Blvd
De Pere, WI 54344
Or email to: HOLU@Humana.com

Humana Inc. Evidence of Health Status for **Associate**

Complete this side for: Life Coverage above Guarantee Issue amount

This section must be completed for the Associate to be covered. Do not leave any questions unanswered or the form will be returned for completion and may lead to a delay in processing your application.

Name and address of current family physician _____

Have you used tobacco products within the last 12 months? Circle Yes or No

	Yes	No
1. Are you currently under any treatment or prescribed medications?.....	☐	☐
2. Have you had unexplained weight loss or fatigues in the past 12 months?.....	☐	☐
3. Have you ever had, been diagnosed with, counseled, consulted, or treated for any of the following: (please circle disease or disorder)		
A. Chest pain; disease of heart, arteries or blood vessels; high or low blood pressure?.....	☐	☐
B. Nervous, mental or emotional disorder; convulsions; epilepsy; unconsciousness?.....	☐	☐
C. Asthma or other disease of lungs or respiratory organs?.....	☐	☐
D. Kidney stones; disease of the kidney, bladder, male or female organs; or infertility?.....	☐	☐
E. Cancer, and/or cancerous tumor? (state type; part of body).....	☐	☐
F. Diabetes; liver or thyroid disease; or enlargement of the lymph nodes?.....	☐	☐
G. Stomach, gall bladder, intestinal or colon disorders?	☐	☐
H. Rheumatoid arthritis or back disorders?.....	☐	☐
I. Phlebitis, paralysis, or any other physical impairment or deformity?.....	☐	☐
J. Alcoholism or drug habit, or been a member of Alcoholics Anonymous?.....	☐	☐
4. Have you been diagnosed or received treatment for AIDS or an AIDS-related complex or other immune system disorder within the past 5 years?.....	☐	☐
5. Have you 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?.....	☐	☐
6. Have you ever had a cesarean section?.....	☐	☐

7. Height_____ft._____in. Weight_____lbs.

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

No.	Person treated	Illness or Impairment & Medications (if any)	Dates Treated	Name/Address or 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 be the best of my knowledge and belief, complete and true and, together with any supplements thereto, shall be the basis for any 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 coverage or insurability, alter any contract, or waive any of the company's other rights or requirements. **I hereby agree that no coverage will be effective until the date specified by the company on the certificate of insurance after this application has been accepted.** I understand that any misrepresentation or omission 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 or omission 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, and any other non-medical information of me or my covered dependents to give to 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 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 my 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-and-one-half years from the date shown below.

Associate Signature X_____Date_____

Humana Inc. Evidence of Health Status for **Spouse/Domestic Partner**

Complete this side for: Life Coverage above Guarantee Issue amount

This section must be completed for the Associate to be covered. Do not leave any questions unanswered or the form will be returned for completion and may lead to a delay in processing your application.

Name and address of current family physician _____

	Yes	No
1. Are you currently under any treatment or prescribed medications?.....	☐	☐
2. Have you had unexplained weight loss or fatigues in the past 12 months?.....	☐	☐
3. Have you ever had, been diagnosed with, counseled, consulted, or treated for any of the following: (please circle disease or disorder)		
A. Chest pain; disease of heart, arteries or blood vessels; high or low blood pressure?.....	☐	☐
B. Nervous, mental or emotional disorder; convulsions; epilepsy; unconsciousness?.....	☐	☐
C. Asthma or other disease of lungs or respiratory organs?.....	☐	☐
D. Kidney stones; disease of the kidney, bladder, male or female organs; or infertility?.....	☐	☐
E. Cancer, and/or cancerous tumor? (state type; part of body)……	☐	☐
F. Diabetes; liver or thyroid disease; or enlargement of the lymph nodes?.....	☐	☐
G. Stomach, gall bladder, intestinal or colon disorders? ……	☐	☐
H. Rheumatoid arthritis or back disorders?.....	☐	☐
I. Phlebitis, paralysis, or any other physical impairment or deformity?.....	☐	☐
J. Alcoholism or drug habit, or been a member of Alcoholics Anonymous?.....	☐	☐
4. Have you been diagnosed or received treatment for AIDS or an AIDS-related complex or other immune system disorder within the past 5 years?.....	☐	☐
5. Have you 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?.....	☐	☐
6. Have you ever had a cesarean section?.....	☐	☐

7. Height_____ft._____in. Weight_____lbs.

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

No.	Person treated	Illness or Impairment & Medications (if any)	Dates Treated	Name/Address or 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 be the best of my knowledge and belief, complete and true and, together with any supplements thereto, shall be the basis for any 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 coverage or insurability, alter any contract, or waive any of the company's other rights or requirements. **I hereby agree that no coverage will be effective until the date specified by the company on the certificate of insurance after this application has been accepted.** I understand that any misrepresentation or omission 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 or omission 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, and any other non-medical information of me or my covered dependents to give to 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 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 my 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-and-one-half years from the date shown below.

Associate Signature X_____Date_____

Spouse Signature X_____Date_____