Large Group 101+ Employee Enrollment Form FOR HUMANA VISION — CONNECTICUT

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in the Large Group 101+ Employee Enrollment Form as "Humana".

Dental, Life and Vision plans insured or administered by Humana Insurance Company.

Print clearly and completely fill in each applicable circle.

Employer / Group name: NEW MILFORD PUBLIC SCHOOLS

Employer / Group city: NEW MILFORD

State: CT

Qualifying Event Instructions

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

Office use only

Qualifying event date (MM/DD/YYYY) ___ / ___ / ____

Benefit effective date (MM/DD/YYYY) ___ / ___ / 2021

Employee / Individual information

Last name | First name | MI

Social Security Number ___ - ___ - ____ | Date of birth (MM/DD/YYYY) ___ / ___ / ____ | Area code (___) | Phone number ___ - ____

Street address

Apt / Suite / PO box number | Gender ❍ Female ❍ Male | Language of choice ❍ English ❍ Spanish

City | State | Zip code | County / Parish

E-mail address

Are you actively at work? ❍ Yes ❍ No If not, reason:

❍ Retiree ❍ COBRA Other: _____

Date of full-time hire (MM/DD/YYYY) ___ / ___ / ____

Do you have a disability that affects your ability to communicate or read? ❍ No ❍ Yes

Are you disabled or unable to perform normal work activities? ❍ No ❍ Yes If yes, indicate reason:_____

Annual salary $ _____ Hours worked per week ___

Occupation _____

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 ❍ Disabled If disabled, indicate reason:_____

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 ❍ Disabled If disabled, indicate reason:_____

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 ❍ Disabled If disabled, indicate reason:_____

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 ❍ Disabled If disabled, indicate reason:_____

Use the following alternate address for these dependents: ❍ 1 ❍ 2 ❍ 3 ❍ 4

Street address

Apt / Suite / PO box number

City | State | Zip code | County

NOT APPLICABLE SKIP

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

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Group # | Benefit # | Class/Div #

Plan name

Within the past 12 months, have you or any covered family individual 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? ❍ Yes ❍ No | Starting date (MM/DD/YYYY) / / | End date, if applicable (MM/DD/YYYY) / /

Coverage Type (check all that apply) ❍ Employee / Individual ❍ Spouse ❍ Child(ren)

Prior dental carrier name: | Orthodontia coverage? ❍ Yes ❍ No | Starting date (MM/DD/YYYY) / / | End date, if applicable (MM/DD/YYYY) / /

Coverage type check all that apply)
❍ Employee / Individual only
❍ Employee / Individual and child(ren)
❍ Employee / Individual and spouse
❍ Family

NOT APPLICABLE SKIP

❍ Yes ❍ No If no, complete waiver section

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Group # | Benefit # | Class/Div #

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

Do you elect basic dependent life? ❍ Yes ❍ No If no, complete waiver section

NOT APPLICABLE SKIP

Do you elect voluntary employee / individual life coverage?
❍ Yes ❍ No If no, complete waiver section
If yes, amount elected (minimum of $15,000):
$, .00

Office use only
Group # | Benefit # | Class/Div #

Voluntary dependent life selection (available only if employee / individual elects voluntary life coverage):

Do you elect voluntary spouse life coverage? ❍ Yes ❍ No If no, complete waiver section

If yes, voluntary spouse life coverage (minimum of $5,000): $, .00

Do you elect voluntary child(ren) life coverage? ❍ Yes ❍ No If no, complete waiver section

HUMANA VISION

Coverage type:
- ❍ Employee / Individual only
- ❍ Employee / Individual & spouse
- ❍ Employee / Individual & child(ren)
- ❍ Family
- ❍ Other

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Group # 745010 | Benefit # | Class/Div #

Plan name

NOT APPLICABLE SKIP

Primary beneficiary
Last name | First name | MI

Relationship to employee / individual

Secondary beneficiary
Last name | First name | MI

Relationship to employee / individual

NOT APPLICABLE SKIP

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: ❍ You (employee) ❍ Dependent 1 ❍ Dependent 2 ❍ Dependent 3 ❍ Dependent 4	❍ N ❍ Y

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 CT-51340-MH), if necessary.

Question# | Person Treated Last name | First Name

Condition | Treatments received

Medications | Current or future treatments or medications

Date diagnosed (MM/DD/YYYY) | Date last seen by a doctor (MM/DD/YYYY)

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 below is evidence of this action.

I hereby waive coverage for (check all that apply):			
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)

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:_____

True and complete acknowledgment

I understand, agree, and represent to the best of my knowledge and belief:
- I have read the Large Group 101+ Employee 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 Large Group 101+ Employee 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 Large Group 101+ Employee 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.
- 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.
- Humana reserves the right to delay medical coverage and/or deny life or dental coverage with any future submissions of the Large Group 101+ Employee Enrollment Form for coverage.
- If any deductions are required for this coverage, I authorize those deductions from my earnings.
- 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 Large Group 101+ Employee Enrollment Form.
- 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 Large Group 101+ Employee Enrollment Form by Humana.
- Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

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 Large Group 101+ Employee 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
If my dependents or I have selected life 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 Large Group 101+ Employee 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 any group coverage

Employee / Individual or legal representative signature _____ **E-Signed:** ☐ Date ☐☐/☐☐/☐☐☐☐

Name and relationship of legal representative (if a covered dependent) _____

OFFICE USE ONLY

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 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 Large Group 101+ Employee 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. These provisions are available to me and the primary applicant in the benefit summary document or other plan literature.

Signed at ___N/A___ 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.