# Large Group 51+ Employee Application and Enrollment Form

ILLINOIS

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in the Large Group 51+ Employee Application and Enrollment Form as "Humana".

HMO plans offered by **Humana Health Plan, Inc**. PPO, Indemnity medical and Life plans insured or administered by **Humana Insurance Company**. Dental PPO, Preventative Plus and Traditional Preferred plans insured or administered by **HumanaDental Insurance Company** or **Humana Insurance Company**. Dental prepaid plans offered and administered by **CompBenefits Dental, Inc**. Vision plans insured or administered by **Humana Insurance Company** or **HumanaDental Insurance Company**. Short Term Disability, Long Term Disability and Workplace Voluntary Benefits plans insured or administered by **Kanawha Insurance Company**.

Print clearly	and co	mple	tely	fill ir	eac	h app	lica	ble (	circl	e.																				
Employer / Gro	oup nar	ne												Em	ploy	/er/	Gro	up c	ity									S	tate	7
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HMO/POS only	/															- 1		1		- [	- 1				U Y	es (	ON C	J		

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): O Full-time student O Disabled If dis	sabled, indicate reason:	
Not applicable for HumanaAccess HMO Primary care physician name	Primary care physician ID #	Current nationt?
HMO/POS only	Primary care physician 15 #	Current patient?  • Yes • No
OB/GYN Primary care physician name (if applicable) HMO/POS only	Primary care physician ID #	Current patient?  • Yes • No
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): ${\bf O}$ Full-time student ${\bf O}$ Disabled ${\bf If}$ dis	sabled, indicate reason:	
Not applicable for HumanaAccess HMO	Drive and a superplanting in ID #	C
Primary care physician name HMO/POS only	Primary care physician ID #	Current patient?  • Yes • No
OB/GYN Primary care physician name (if applicable)	Primary care physician ID #	Current patient?
HMO/POS only		• Yes • No
<b>3</b> Dependent last name First name	MI	Gender
		<b>○</b> Female <b>○</b> Male
Social Security Number Date of birth (MM/DD/YYYY)	Relationship	
	○ Spouse ○ Child ○ Other:_	
Dependent status (if applicable): • Full-time student • Disabled If dis	sabled, indicate reason:	
Not applicable for HumanaAccess HMO		
Primary care physician name	Primary care physician ID #	Current patient?
HMO/POS only		• Yes • No
OB/GYN Primary care physician name (if applicable)	Primary care physician ID#	Current patient?
HMO/POS only		• Yes • No
4 Dependent last name First name	MI	Gender
		O Female O Male
Social Security Number Date of birth (MM/DD/YYYY)	Relationship	
	○ Spouse ○ Child ○ Other:_	
Dependent status (if applicable): • Full-time student • Disabled If dis	sabled. indicate reason:	
Not applicable for HumanaAccess HMO		
Primary care physician name	Primary care physician ID#	Current patient?
HMO/POS only		O Yes O No
OB/GYN Primary care physician name (if applicable)	Primary care physician ID#	Current patient?
HMO/POS only		O Yes O No

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Coverage type:	• Emplo	vee /	/ Indivi	idual	onlv			Off	ice u	ise (	only															
	<ul><li>Emplo</li><li>Emplo</li><li>Family</li><li>Other</li></ul>	oyee / , oyee / , /	/ Indivi	idual	& spc		n)	Gro	up#							Ве	nefi	t #							lass	s/Div#
Plan name													Ne	twoı	k na	me										
Do you or any cov Medicare? O Yes Medicare ID or mo	O No I	f yes, l	ist all:							lete		Hum	nanc	ı to p	roce	ss a	ny n	nedi	ical				med	ical	plan	ı, or
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Have you or any o																				plaı	n) in	the	pas	t 18	mor	nths?
Prior medical carr	rier name	:							7	P	rior n	nedi	cal c	arrie	r nar	ne:										
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Starting date (MM Lend date, if application of the control of the	1		/YYY)	(che	erage eck all Emplo Spouse Child(r	that o yee / I			al		tartir nd de	]/			/			/YYY	Y)	(	(ched C Er C Sp	rage ck all mplo pous nild(r	that yee i	арр		al
Medical Health I	History (1	or 51	-100 g	roup	s) - D	o no	t su	bmi	it mo	re t	han	90 c	lays	pric	r to	the	effe	ecti	ve (	date	е					
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If you answered " signed and dated									ovid	e de	tails	belo	)W ai	nd sp	pecify	/ the	e qu	esti	on r	num	nber.	. Att	ach	addi	ition	al
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#### Do you elect the Health Savings Account? Office use only • Yes • No If no, complete waiver section 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. Beneficiary for this account will be the employee / individual 's estate. You may change beneficiary information on file with the bank that administers the HSA once the account is established. Flexible Spending Account (FSA) Do you elect the flexible health account? Office use only Group# Benefit # Class/Div# • Yes • No If no, complete waiver section FSA HC Annual amount elected: \$ .00 Start date (MM/DD/YYYY) End date (MM/DD/YYYY) Do you elect the flexible dependent health Office use only account? • Yes • No If no, complete waiver Group # Benefit# Class/Div# section FSA DC Annual amount elected: .00 Start date (MM/DD/YYYY) End date (MM/DD/YYYY) Dental Coverage type: • Employee / Individual only Office use only Benefit# Class/Div# Group # • Employee / Individual & spouse • Employee / Individual & child(ren) • Family Other 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) Orthodontia Starting date End date, if applicable (MM/DD/YYYY) Current dental carrier name: (MM/DD/YYYY) coverage? O Yes O No / Coverage Type (check all that apply) • Employee / Individual • Spouse • Child(ren) Starting date Orthodontia End date, if applicable Prior dental carrier name: coverage? (MM/DD/YYYY) (MM/DD/YYYY) O Yes O No Coverage type check all that apply) • Employee / Individual only • Employee / Individual and spouse • Employee / Individual and child(ren) • Family Employee primary care dentist name Dentist ID# Current patient? **DHMO** O Yes O No Dependent primary care dentist name Dentist ID# Current patient? 1 DHMO O Yes O No 2 DHMO O Yes O No 3 DHMO • Yes • No

Health Savings Account (HSA) Applicable only with High Deductible Health Plan selection

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Basic Life / AD&D					
Do you elect basic employee / individual O Yes O No If no, complete waiver so	al life coverage? ection	Office use only Group #	Benefit #		Class/Div#
Class (employer / group will provide you	u with this informa	tion if needed)			
Do you elect basic dependent life? $\circ$ Y	es O No If no, co	mplete waiver section			
Voluntary Life / AD&D					
Do you elect voluntary employee / indircoverage?  • Yes • No If no, complete waiver so If yes, amount elected (minimum of \$25)  • 100	ection	Office use only Group #	Benefit #		Class/Div#
Voluntary dependent life selection (ave	ailable only if empl	ovee / individual elects voluntary life	coverage):		
Do you elect voluntary spouse life cove	,		J-,-		
If yes, voluntary souse life coverage (m	3		.00		
Do you elect voluntary child(ren) life co	overage? • Yes •	No If no, complete waiver section			
Vision	-				
	lual only	Office use only			
Coverage type:   Coverage type:   Employee / Individual Coverage /	lual & spouse	Group #	Benefit #		Class/Div#
Plan name					
Short Term Disability					
Do you elect short term disability coverage?  • Yes • No If no, complete waiver section  Buy-up percent/amount	Office use only Group #	Benefit #		Class# E	Div#
Long Term Disability					
Do you elect long term disability coverage?  • Yes • No If no, complete waiver section Buy-up percent/amount	Office use only Group #	Benefit #		Class# E	)iv #

Group Teri	m Life / AD&D						
Office use	only Group#	Bei	nefit#		Class#	Div#	
Coverage	e requested for (check all that apply)	Coverage reques	sted (comple iice of benefit	te only if plan p schedules)	provides a	Cost per pay	period
Employee /	Basic Term Life			,	\$		.00
Individual	○ Supplemental Term Life'				ς -	,	.00
	○ Basic AD&D				\$	,	.00
	○ Supplemental AD&D				\$	,	.00
Spouse	O Basic Term Life				\$	,	.00
	○ Supplemental Term Life'				\$	,	.00
	○ Basic AD&D				\$	,	.00
	○ Supplemental AD&D				\$	,	.00
Child(ren)	O Basic Term Life				\$	,	.00
	○ Supplemental Term Life'				\$	,	.00
	○ Basic AD&D				\$	,	.00
	○ Supplemental AD&D				\$	,	.00
*Complete E	Evidence of Insurability form i	selecting one of the	se benefit am	nounts.			
Workplace	e Voluntary Benefits: Option	al riders availability l	oased on emp	oloyer / group e	election.		
Accident -	2012						
			C1 #			5: "	
	only Group#		nefit#		Class#	Div#	
• Accident		Benefit Level: • 1					
Coverage ty	pe: • Employee / Individ • Family	ual only 🔾 Empl	oyee / Individ	lual and spous	e • Employee	/ Individual and (	child(ren)
Disability 1	Income Plus						
Office use of	only Group#	Bei	nefit#		Class#	Div#	
	y Income Covering Accident o		YC				
	nefit Period: 3 Mon mination Period: 0 0/7 0 180/1	<b>O</b> 7/7	<ul><li>1 Year</li><li>0/14</li></ul>	• 2 Year • 14/14	• 3 Year • 30/30	<b>O</b> 60/60 <b>O</b>	90/90
	y Income Covering Accident o					Monthly benefit	
	nefit Period: O 3 Mon		O 1 Year	<b>2</b> Year	○ 3 Year \$	,	.00
	mination Period: • 0/7 l Disability Income Benefits:	○ 7/7 ○ ICU/CCU Benefit	○ 0/14 ○ \$200	• 14/14 • \$400	<b>\$</b> 600	<b>S</b> \$800	
ориона	Disability Theorne benefits.	• Physical Therapy				<b>3</b> 3000	
		○ COBRA Rider		COBRA monthly	y benefit \$	,	.00
Level Term	n Life						
Office use of	only Group#	Bei	nefit#		Class#	Div#	
Base Pla	rm Life O N O Y Coverd In: O 10 Year Term O 20 Year I Benefit: O Automatic Benef		e / Individual	only O Spo	use <b>O</b> Child(rei	n) O No Coverd	ıge
Employe \$	ee / Individual Benefit	Spouse Benefi \$	t	.00	Child(ren)	Benefit	.00
of heart atto If yes, pleas	loyer or group has elected the ack, heart disease, stroke, or c e indicate whether this applie bloyee / individual) • Spouse	ancer diagnosis prior s to you (employee /	to age 60? C individual), y	NOY	·	t, brother, or siste	er with a history

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Critical Illness
Office use only   Group #     Benefit #   Class #     Div #
O Critical Illness O N O Y Coverage type: O Employee / Individual only O Employee / Individual and spouse O Critical Illness and Cancer O N O Y Employee / Individual and child(ren) O Family
Optional Benefits: • Automatic Benefit Increase • Health Screening • Return on Premium Employee / Individual Benefit \$ .00
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? O N O Y If yes, please indicate whether this applies to you (employee / individual), your spouse or a dependent. O You (employee / individual) O Spouse O Dependent Name
Group Lump Sum Cancer
Office use only Group # Benefit # Class # Div #
O Group Lump Sum Cancer ONOY Coverage type: O Employee / Individual only O Employee / Individual and spouse O Employee / Individual and child(ren) O Family
Does anyone on this application have a parent, brother, or sister with a history of cancer diagnosis prior to age 60?  O N O Y If yes, please indicate whether this applies to you (employee / individual), your spouse or a dependent.  O You (employee / individual) O Spouse O Dependent Name
Rider: • Automatic Benefit Increase • Health Screenings Benefit \$ .00
Supplemental Health
Office use only Group # Benefit # Class # Div #
O Supplemental Health ONOY Coverage type: O Employee / Individual only O Employee / Individual and spouse
Plan type: O 1 O 2 O 3 O 4
Hospital Indemnity
Office use only Group # Benefit # Class # Div #
O Hospital Indemnity ONOY  Coverage type: O Employee / Individual only O Employee / Individual and spouse O Employee / Individual and child(ren) O Family
Plan type: O 1 O 2 O 3 O 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? O N O Y  If yes, please indicate whether this applies to you (employee / individual), your spouse or a dependent.  O You (employee / individual) O Spouse O Dependent Name
Beneficiary Information for Life, Disability and Workplace Voluntary Benefits
Primary beneficiary Last name First name MI
Relationship to employee / individual
Secondary beneficiary Last name First name MI
Relationship to employee / individual

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

<ol> <li>Is anyone on this application currently taking any prescribed medication, or do you periodically take medication for a recurrent condition?</li> <li>In the past 12 months has any applicant used any tobacco product? If yes, applies to:</li> </ol>													n	O N	O Y													
2a. • Y	In the past 12 m 'ou (employee)		ıs has Deper			olica	nt us	sed (	any 1	toba	CCO	pro	oduc	t? It	f yes	s, ap	plie	sto	):								O N	Υ
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2b.	2b. Is any applicant currently a smoker? If yes, applies to:  • You (employee) • Dependent 1															O N	O Y											
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3.	In the past 12 m	onth	s ha	10 \	/OLL M	nicco	d 5 d	or m	ore	cons	2001	ıtiv	- day	IS O	fw	ork d	110	to a	n in	iur	, or i	llne	200		r th	an	O N	O Y
٦.	as a result of a c																											9 1
4.	Has anyone on t	his a	pplico	atio	n bee	en tr	eate	d or	diag	gnos	ed	with	n an	imr	nun	e sy:	stei	m d	isor	der	(i.e.	Lup	ous,	ITP	), AI	DS	O N	O Y
	or an AIDS-relat scope of his/her			x b	y a p	hysid	cian	or a	n ap	prop	oriat	tely	licer	rse	d cli	nica	l pro	ofes	sio	nal (	actii	ng v	vith	in t	ne			
5.	Within the past consulted, or tre	5 yea ated	ırs, ho by a	ıs a doc	nyon tor, i	ie or nclu	this ding	app	olica gery,	tion , for (	bee any	en d v of t	iagn the f	ose ollo	ed w win	ith d g:	lise	ase	s or	dis	orde	ers r	elat	ted <sup>-</sup>	to, c	oun	seled,	
α.	Coronary artery dis- any disease of the o hemophilia; phlebit higher than 140/90	arteri is; hi	es, or	blo	od d	isorc	ders;	ane	mia		O N O Y		i.	C	Diab or er	etes Ilarg	; liv	er o ent	r th of t	yroi he l	d di lym <sub>l</sub>	sea oh r	se; l	hep es?	atiti	s; ciı	rrhosis;	O N O Y
b.	Nervous, mental or epilepsy; unconscio Parkinson's Disease	usne	ss; M	ultii	ple S	er; cc	nvul sis;	lsior	ns;		N O Y		j.	S	iton	nach ders	, gc	ıll b	lado	der,	dige	estiv	∕e, i	ntes	stinc	ıl, or	colon	O N
C.	Stroke; Transient Iso	chem	nic Att	ack	(TIA	\)?					) N ) Y		k.			ımat ders		art	hrit	is; c	r bo	ıck	diso	rde	rs; o	r joii	nt	O N O Y
d.	d. Emphysema; asthma, or other disease of lungs, or respiratory organs?  O N O Y  Respiratory organs?												nt oi	r	O N O Y													
e.	End stage renal disc	ease;	disec	ise	of kid	dney	?				) N ) Y		m.		hro	nic F	atio	gue	Syr	dro	me	'Fib	rom	ıyalı	gia?			O N O Y
f.	Kidney stones; blad	der?								- 1	) N ) Y		n.	C	disor	ases der v ogre	whi	ch ł	าตร	led	or n	nay	lea	d to	аре	erm	ase or anent n?	O N
g.	Male or female organs; or infertility?  ON OY  O. Alcoholism or drug habit? OY OY																											

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YO

h. Cancer, and/or cancerous tumor; including skin cancer? ON

																			n to	hav	e any	/ dic	igno	Stic	tes	t,	O	N	0	Y
<ul> <li>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?</li> <li>8. Is anyone on this application currently pregnant? If yes, please indicate anticipated delivery date below.</li> </ul>															O	N	0	Υ												
Is any	one c	n this	appl	icat	ion													ated	del	ivery	date	e be	low.				O	N	0	Υ
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IL-72001 10/2015 9 Reorder # IL-52000-LG 1/2016

## True and complete acknowledgement

I understand, agree, and represent:

- I have read the Large Group 51+ 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 Large Group 51+ 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 Large Group 51+ 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.
- 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 51+ Employee Application and Enrollment Form for coverage.
- 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 Large Group 51+ 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 Large Group 51+ Employee Application and Enrollment Form to cover the benefit actually issued.
- 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 51+ Employee Application and Enrollment Form by Humana.
- Any person who willingly and knowingly submits the Large Group 51+ Employee Application and Enrollment Form containing a false, incomplete or deceptive statement may be quilty of insurance 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, eliqibility 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 51+ 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 Large Group 51+ 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 any group	coverage
Employee / Individual or legal representative signature	Date // // // // // // // // // // // // //
Name and relationship of legal representative(if a covered dependent)	
Agent / Producer Information	
If applying for workplace voluntary benefits, this section to be complete.	eted 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 disa	pility insurance policy(s) and/or annuity(s)? •• ONOY
As the Writing Agent / Producer, I acknowledge that I am responsible Employee Application and Enrollment Form in order to fully and according the offering or insuring entity, or one of its subsidiaries. These provoummary document or other plan literature.	rately represent the terms and conditions of the plans and services
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.

## Additional Details to Medical Questions

This information should not be submitted more than 60 days prior to the effective date. Please print clearly.

Question # & letter	Person treated (Last name, Fi	irst name)				
Condition		Treatments received				
Medications prescribed		Current or future treatments or medi	cations			
Date diagnosed//		Date last seen by a doctor/_/_				
Question # & letter	Person treated (Last name, Fi	irst name)				
Condition		Treatments received				
Medications prescribed		Current or future treatments or medi	cations			
Date diagnosed//		Date last seen by a doctor/_/_				
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Condition	<u> </u>	Treatments received				
Medications prescribed		Current or future treatments or medi	cations			
Date diagnosed//		Date last seen by a doctor/_/_				
Employee signature			Date//			
Spouse signature (if covered depe	ndent)		_ Date//			
Child signature (if covered depend	dent over the legal age)		_ Date//			
Child signature (if covered depend	dent over the legal age)		_ Date//			
Child signature (if covered depend	dent over the legal age)		Date//			

Life plans insured or administered by **Humana Insurance Company**. Workplace Voluntary Benefits plans insured or administered by **Kanawha Insurance Company**.