Large Group 51+ Employee and Individual Application and Enrollment Form — FLORIDA

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

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

Print clearly and completely fill in each applicable circle.

Employer / Group name: Florida School Retiree Benefits Consortium #735974

Employer / Group city:

State: FL

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

Retirement Event date (MM/DD/YYYY)

Benefit effective date (MM/DD/YYYY)

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 Retirement (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

Dental

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

Office use only
Group # 7 3 5 9 7 4 | Benefit # | Class/Div #

Plan name ***Select one Plan name - High PPO, Middle PPO, Low PPO, DHMO High, DHMO Low

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

	Employee primary care dentist name	Dentist ID #	Current patient?
DHMO			○ Yes ○ No
	Dependent primary care dentist name	**Dentist ID #**	**Current patient?**
1 DHMO			○ Yes ○ No
2 DHMO			○ Yes ○ No
3 DHMO			○ Yes ○ No

Vision

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

Office use only
Group # 7 3 5 9 7 4 | Benefit # | Class/Div #

Plan name **Select one Plan name - Vision High or Vision Low

Waiver (refusal of coverage)

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 / group ○ Other:

True and complete acknowledgment

I understand, agree, and represent:

- I have read the Large Group Employee and Individual 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 Employee and Individual 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 Employee and Individual 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.
- 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 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 Employee and Individual Application and 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 Employee and Individual Application and Enrollment Form by Humana.
- Any person who willingly and knowingly submits the Large Group Employee and Individual Application and Enrollment Form containing a false, incomplete or deceptive statement may be guilty 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, 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 Employee and Individual Application and Enrollment Form, claim or as may be otherwise lawfully required, or as I (we) may further authorize.

The Large Group Employee and Individual 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

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.

Employee / Individual or legal representative signature _____ Date __ __ / __ __ / __ __ __ __

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

Discrimination is Against the Law

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Humana Inc. and its subsidiaries do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Humana Inc. and its subsidiaries provide:

- Free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.
- Free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as translated documents or oral interpretation.

If you need these services, call 1-877-320-1235, or if you use a TTY, call 711.

If you believe that Humana Inc. and its subsidiaries have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Discrimination Grievances
P.O. Box 14618
Lexington, KY 40512-4618

If you need help filing a grievance, call 1-877-320-1235 or if you use a TTY, call 711.

You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800–368–1019, 800-537-7697 (TDD)
Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**

Multi-Language Interpreter Services

English: ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-877-320-1235 (TTY: 711).

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-320-1235 (TTY: 711).

繁體中文 (Chinese): 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-320-1235（TTY: 711）。

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-320-1235 (TTY: 711).

한국어 (Korean): 주의 : 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다 . 1-877-320-1235 (TTY: 711)번으로 전화해 주십시오 .

Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-320-1235 (TTY: 711).

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-320-1235 (телетайп: 711).

Kreyòl Ayisyen (French Creole): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-320-1235 (TTY: 711).

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-320-1235 (ATS : 711).

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-320-1235 (TTY: 711).

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-877-320-1235 (TTY: 711).

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-320-1235 (TTY: 711).

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-320-1235 (TTY: 711).

العربية (Arabic):
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-320-1235 (رقم هاتف الصم والبكم: 711).

日本語 (Japanese): 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-877-320-1235（TTY：711）まで、お電話にてご連絡ください。

فارسی (Farsi):
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-877-320-1235 (TTY: 711) تماس بگیرید.

Diné Bizaad (Navajo): Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-877-320-1235 (TTY: 711).