



Humana

Pima County Open Enrollment- Life Insurance Changes

If you are not making any changes to your Voluntary Supplemental Life Insurance coverage or to your Dependent Life Insurance coverage, you do not need to do anything.

If you are increasing your Voluntary Supplemental Life Insurance coverage, or adding a Spouse/Domestic Partner to your Dependent Life Insurance coverage, please complete the Humana Enrollment Form and Humana (EOI) Evidence of Insurability Form. **If you are adding a Spouse/Domestic Partner, their signature is required on the EOI Form as well.** Please submit these forms to: pimaeoi@humana.com, or fax to 1-888-235-3260.

You will also need to update your enrollment changes in Pima County's ADP/HR Benefit Solution website.

If you are only adding a Dependent Child, you do not need to complete any Humana forms; you simply need to update the enrollment change in Pima County's ADP/HR Benefit Solution website.

Humana EOI Cover page

Employee Name: _____

Humana Group Number 561416

If there are questions regarding your application

Best phone number to contact you: _____

If you would prefer contact via email: _____

If you are covering dependents please provide:

Spouse name _____	Date of Birth ____/____/____
Child name _____	Date of Birth ____/____/____
Child name _____	Date of Birth ____/____/____
Child name _____	Date of Birth ____/____/____
Child name _____	Date of Birth ____/____/____
Child name _____	Date of Birth ____/____/____
Child name _____	Date of Birth ____/____/____

Email OR fax this form with the Humana EOI form to:

Email: PimaEOI@humana.com

Fax: 1-888-235-3260

Humana Employee Enrollment Form - Life, ARIZONA

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in this application as "Humana".

Life and Vision plans insured or administered by Humana Insurance Company. Dental Prepaid plans underwritten by Employers Dental Services. All other Dental plans insured or administered by HumanaDental Insurance Company or Humana Insurance Company. CompBenefits Vision plan insured and administered by CompBenefits Insurance Company.

Please print clearly and fill in each applicable circle.

Proposed effective date: 07 / 01 / 2012

Company name <u>Pima County</u>	Company city <u>Tucson</u>	State <u>AZ</u>
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Enrollment Information AZ-72000-EI 3/2008

Relationship	Last name, First name MI	Height (ft / in)	Weight (lbs.)	Gender	Full-time student?	Date of birth	Disabled? If yes, indicate reason.
Employee		/		<input type="radio"/> F <input type="radio"/> M	N/A	-- / -- / --	<input type="radio"/> N Reason: <input type="radio"/> Y
Spouse		/		<input type="radio"/> F <input type="radio"/> M	N/A	-- / -- / --	<input type="radio"/> N Reason: <input type="radio"/> Y
Child		/		<input type="radio"/> F <input type="radio"/> M	<input type="radio"/> N <input type="radio"/> Y	-- / -- / --	<input type="radio"/> N Reason: <input type="radio"/> Y
Child		/		<input type="radio"/> F <input type="radio"/> M	<input type="radio"/> N <input type="radio"/> Y	-- / -- / --	<input type="radio"/> N Reason: <input type="radio"/> Y
Child		/		<input type="radio"/> F <input type="radio"/> M	<input type="radio"/> N <input type="radio"/> Y	-- / -- / --	<input type="radio"/> N Reason: <input type="radio"/> Y
Other (specify):		/		<input type="radio"/> F <input type="radio"/> M	<input type="radio"/> N <input type="radio"/> Y	-- / -- / --	<input type="radio"/> N Reason: <input type="radio"/> Y

EMPLOYEE INFORMATION: **HOURS WORKED PER WEEK:** RETIREE **DATE OF FULL-TIME HIRE:** -- / -- / --

SSN #	Street address	APT / Suite / Box
City	State	Zip code
Language: <input type="radio"/> English <input type="radio"/> Spanish	Email address	
Phone # ()		

Group #:	Benefit #:	Class/Div:	AZ-72000-HP
Coverage type: <input type="radio"/> Employee only <input type="radio"/> Employee and spouse <input type="radio"/> Employee and child(ren) <input type="radio"/> NO COVERAGE (complete waiver)	Plan name		
Prior dental coverage during the last 12 months (individual or other group coverage)? <input type="radio"/> N <input type="radio"/> Y	Prior dental insurance carrier name		
Prior dental insurance carrier name	Prior coverage type:	Effective date:	Policy #
Prior orthodontia coverage in the past 12 months? <input type="radio"/> N <input type="radio"/> Y	Prior carrier phone # ()	Term date:	

Group #:	Benefit #:	Class/Div:	AZ-72000-BL 3/2008
Primary beneficiary name (Last, First MI)	Secondary beneficiary name (Last, First MI)		
Class (if you will provide you this information if needed)	Annual salary (if applicable) \$	Basic dependent life? <input type="radio"/> N <input type="radio"/> Y If no, complete waiver section.	

Group #:	Benefit #:	Class/Div:	AZ-72000-VL 3/2008
Voluntary employee life coverage? <input type="radio"/> N <input type="radio"/> Y	Amount (min \$15,000) \$	Primary beneficiary name (Last, First MI)	Secondary beneficiary name (Last, First MI)
Voluntary spouse life coverage? <input type="radio"/> N <input type="radio"/> Y	Amount (min. \$5,000) \$	Voluntary child(ren) life coverage? <input type="radio"/> N <input type="radio"/> Y	Annual employee salary (if applicable) \$

Group #:	Benefit #:	Class/Div:	AZ-72000-VS 3/2008
Coverage type: <input type="radio"/> Employee only <input type="radio"/> Employee and spouse <input type="radio"/> Employee and child(ren) <input type="radio"/> NO COVERAGE (complete waiver)	Plan name		

Last name: _____

First name: _____

AZ-72000-AA

I acknowledge that I was given the opportunity to apply for group coverage available to me and my dependents through my employer. I affirm that I was not pressured or forced by my employer, the writing agent, or Humana into waiving (declining) coverage. If I have declined coverage offered to me or my dependents, my signature is evidence of this fact.

<p>I hereby waive coverage for (check all that apply):</p> <p>Dental for: <input type="radio"/> Myself <input type="radio"/> My spouse <input type="radio"/> My dependent child(ren)</p> <p>Basic Life for: <input type="radio"/> Myself <input type="radio"/> My spouse <input type="radio"/> My dependent child(ren)</p> <p>Vision for: <input type="radio"/> Myself <input type="radio"/> My spouse <input type="radio"/> My dependent child(ren)</p>	<p>I do not apply for group coverage because of:</p> <p><input type="radio"/> Personal coverage</p> <p><input type="radio"/> Medicare Supplement</p> <p><input type="radio"/> Individual coverage</p> <p><input type="radio"/> Coverage under another carrier's plan provided by my employer</p> <p><input type="radio"/> Other: _____</p>
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Agreement AZ-72000-AA 3/2008

True and complete acknowledgement

I understand, agree and represent:

- I have read this document 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 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 this application for coverage is accepted, coverage will be effective on the date specified by Humana on the certificate of coverage/certificate of insurance. 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.
- In the event that I should decide to apply for coverage hereafter, that subsequent application shall be subject to the applicable terms and conditions of the master group contract(s) or plan provisions which may require additional limitations and waiting periods.
- I may be required to furnish, at my own expense, evidence of health status satisfactory to Humana.
- 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 application 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 for the purposes of depositing any contributions.
- Any misrepresentation contained herein relied on by Humana may be used to reduce or deny a claims or void the contract within the contestable period if such misrepresentation materially affected the acceptance of the risk.

Authorization

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.

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 an application, claim or as may be otherwise lawfully required, or as I (we) may further authorize. 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.
- A photographic copy of this authorization shall be as valid as the original.
- This authorization shall be valid for two years from the date shown below and I have the right to revoke this authorization at any time by writing to Humana's Privacy Office.

This document, together with any supplements, will form part of any contract and be the basis for any certificate of coverage/certificate of insurance issued.

Signature - please sign below if enrolling or waiving group coverage. AZ-72000-SA 3/2008

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 or legal representative signature: _____ Date: _____

Name and relationship of legal representative: _____

Group number: _____ Last name: _____ First name: _____

Evidence of Health Status

Relationship	Last name, First name MI	Height (ft / in)	Weight (lbs.)	Disabled? If yes, indicate reason.	SSN #
Employee		/		<input type="radio"/> N Reason: _____ <input type="radio"/> Y	
Spouse		/		<input type="radio"/> N Reason: _____ <input type="radio"/> Y	
Child		/		<input type="radio"/> N Reason: _____ <input type="radio"/> Y	
Child		/		<input type="radio"/> N Reason: _____ <input type="radio"/> Y	
Child		/		<input type="radio"/> N Reason: _____ <input type="radio"/> Y	
Other (specify):		/		<input type="radio"/> N Reason: _____ <input type="radio"/> Y	

This information should not be submitted more than 60 days prior to the effective date.
 Complete this section for applicants requesting Life insurance over the guarantee issue amount and all late enrollees applying for Life coverage.

1. Are you or any dependent currently under any treatment or prescribed medications? N Y

2. Within the past 5 years, have you or any eligible dependent to be covered been diagnosed with, counseled, consulted or treated by a doctor for any of the following:

a	Coronary artery disease, chest pain, or any disease of the arteries or blood vessels; phlebitis; high blood pressure?	<input type="radio"/> N <input type="radio"/> Y	f	Diabetes; liver or thyroid disease; or enlargement of the lymph nodes?	<input type="radio"/> N <input type="radio"/> Y
b	Nervous, mental or emotional disorder; convulsions; epilepsy; unconsciousness?	<input type="radio"/> N <input type="radio"/> Y	g	Stomach, gall bladder, intestinal or colon disorders?	<input type="radio"/> N <input type="radio"/> Y
c	Asthma or other disease of lungs or respiratory organs?	<input type="radio"/> N <input type="radio"/> Y	h	Rheumatoid arthritis or back disorders?	<input type="radio"/> N <input type="radio"/> Y
d	Kidney stones; disease of kidney, bladder, male or female organs; or infertility?	<input type="radio"/> N <input type="radio"/> Y	i	Paralysis, or any other physical impairment or deformity?	<input type="radio"/> N <input type="radio"/> Y
e	Cancer, and/or cancerous tumor? (state type & part of body in details section below)	<input type="radio"/> N <input type="radio"/> Y	j	Alcoholism or drug habit, or been a member of Alcoholics Anonymous?	<input type="radio"/> N <input type="radio"/> Y

3. Have you or any dependent been diagnosed or received treatment for an immune system disorder (i.e. Lupus, ITP), AIDS or an AIDS-related complex? N Y

4. During the past 5 years, have you or any dependent had hospitalization or surgery scheduled or completed, had any injury, illness, medical attention or medical advice or treatment for any reason not already mentioned? N Y

5. Are you or any dependent to be covered pregnant? N Y

If you answered "yes" to any of the questions above, please provide details below and specify the question #.
 Attach additional signed and dated sheets if necessary.

Question # & letter	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 ___/___/_____

Question # & letter	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 ___/___/_____

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 or legal representative signature: _____ Date: _____
 Name and relationship of legal representative: _____
 Spouse signature: _____ Date: _____