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

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".

Medical, Dental and Vision plans provided by Humana Health Benefit Plan of Louisiana, Inc. Life plans insured by Humana Insurance Company. Workplace Voluntary Benefits plans, Short-Term and Long-Term Disability plans insured by Kanawha Insurance Company.

Print clearly and completely fill in each applicable circle.

Employer / Group name: NEW BEGINNINGS SCHOOLS

Employer / Group city: NEW ORLEANS

State: LA

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) ___ / ___ / ____

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

HMO/POS only — Primary care physician name | Primary care physician ID # | Current patient? ❍ Yes ❍ No

HMO/POS only — OB/GYN Primary care physician name (if applicable) | Primary care physician ID # | Current patient? ❍ Yes ❍ No

Dependent information

Enter information for each covered dependent, including spouse / domestic partner.

1 Dependent last name | First name | MI | Gender ❍ Female ❍ Male

Social Security Number ___ - ___ - ____ | Date of birth (MM/DD/YYYY) __ / __ / ____ | Relationship ❍ Spouse / Domestic partner ❍ Child ❍ Other:_____

Dependent status (if applicable): ❍ Full-time student ❍ Disabled If disabled, indicate reason:_____

Not applicable for HumanaAccess HMO

HMO/POS only — Primary care physician name | Primary care physician ID # | Current patient? ❍ Yes ❍ No

HMO/POS only — OB/GYN Primary care physician name (if applicable) | Primary care physician ID # | Current patient? ❍ Yes ❍ No

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2 Dependent last name | First name | MI | Gender ❍ Female ❍ Male

Social Security Number ___ - ___ - ____ | Date of birth (MM/DD/YYYY) __ / __ / ____ | Relationship ❍ Spouse / Domestic partner ❍ Child ❍ Other:_____

Dependent status (if applicable): ❍ Full-time student ❍ Disabled If disabled, indicate reason:_____

Not applicable for HumanaAccess HMO

HMO/POS only — Primary care physician name | Primary care physician ID # | Current patient? ❍ Yes ❍ No

HMO/POS only — OB/GYN Primary care physician name (if applicable) | Primary care physician ID # | Current patient? ❍ Yes ❍ No

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3 Dependent last name | First name | MI | Gender ❍ Female ❍ Male

Social Security Number ___ - ___ - ____ | Date of birth (MM/DD/YYYY) __ / __ / ____ | Relationship ❍ Spouse / Domestic partner ❍ Child ❍ Other:_____

Dependent status (if applicable): ❍ Full-time student ❍ Disabled If disabled, indicate reason:_____

Not applicable for HumanaAccess HMO

HMO/POS only — Primary care physician name | Primary care physician ID # | Current patient? ❍ Yes ❍ No

HMO/POS only — OB/GYN Primary care physician name (if applicable) | Primary care physician ID # | Current patient? ❍ Yes ❍ No

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4 Dependent last name | First name | MI | Gender ❍ Female ❍ Male

Social Security Number ___ - ___ - ____ | Date of birth (MM/DD/YYYY) __ / __ / ____ | Relationship ❍ Spouse / Domestic partner ❍ Child ❍ Other:_____

Dependent status (if applicable): ❍ Full-time student ❍ Disabled If disabled, indicate reason:_____

Not applicable for HumanaAccess HMO

HMO/POS only — Primary care physician name | Primary care physician ID # | Current patient? ❍ Yes ❍ No

HMO/POS only — OB/GYN Primary care physician name (if applicable) | Primary care physician ID # | Current patient? ❍ Yes ❍ No

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

Street address

Apt / Suite / PO box number

City | State | Zip code | County

Medical

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

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

Plan name: PLAN 1 $250 DED_____ OR PLAN 2 _____ $3,000 DEDUCTIBLE

Do you or any covered dependent(s) currently have other medical coverage, such as a spouse's / domestic partner's plan, another Humana medical plan, or Medicare? ❍ Yes ❍ No If yes, list all: (This section must be completed for Humana to process any medical claims.)

Medicare ID or medical carrier name:

Starting date (MM/DD/YYYY) / /

End date, if applicable (MM/DD/YYYY) / /

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

Medicare ID or medical carrier name:

Starting date (MM/DD/YYYY) / /

End date, if applicable (MM/DD/YYYY) / /

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

Have you or any covered dependent(s) had medical insurance from a company (including another Humana plan) in the past 18 months? ❍ Yes ❍ No If yes, list all: (This section must be completed for Humana to process any medical claims.)

Prior medical carrier name:

Starting date (MM/DD/YYYY) / /

End date, if applicable (MM/DD/YYYY) / /

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

Prior medical carrier name:

Starting date (MM/DD/YYYY) / /

End date, if applicable (MM/DD/YYYY) / /

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

NOTICE - YOU MUST PERSONALLY BEAR ALL COSTS IF YOU UTILIZE HEALTH CARE NOT AUTHORIZED BY THIS PLAN OR PURCHASE DRUGS WHICH ARE NOT AUTHORIZED BY THIS PLAN.

Medical Health History (for 51-100 groups) - Do not submit more than 90 days prior to the effective date

1. Within the past 24 months have you or any dependent to be covered had or been treated for an illness or injury, had surgery or hospitalization recommended, or are currently pregnant? ❍ N ❍ Y
2. Within the past 24 months have you or any dependent to be covered been prescribed medication? ❍ N ❍ Y
3. Have you or any dependent to be covered incurred medical expenses in excess of $7,500 in the past 12 months? ❍ 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 LA-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)

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

Do you elect the Health Savings Account?
❍ Yes ❍ No If no, complete waiver section

If you have medical coverage under another plan, you may not be eligible for an HSA. Please check with your tax advisor for details.

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

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?
❍ Yes ❍ No If no, complete waiver section

Annual amount elected:
$, .00

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

Start date (MM/DD/YYYY) | End date (MM/DD/YYYY)

Do you elect the flexible dependent health account? ❍ Yes ❍ No If no, complete waiver section

Annual amount elected:
$, .00

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

Start date (MM/DD/YYYY) | End date (MM/DD/YYYY)

Dental

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

Office use only
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 / domestic partner'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 / Domestic partner ❍ 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 spouse / domestic partner ❍ Employee / Individual and child(ren) ❍ 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

Basic Life / AD&D

Do you elect basic employee / individual life coverage?
❍ Yes ❍ No If no, complete waiver section

Office use only
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.
Accelerated benefits within the policy may be taxable. You should consult your personal tax advisor to assess the impact of the benefit.

Voluntary Life / AD&D

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 / domestic partner life coverage? ❍ Yes ❍ No If no, complete waiver section
If yes, voluntary spouse /domestic partner life coverage (minimum of $5,000): $, .00

Do you elect voluntary child(ren) life coverage? ❍ Yes ❍ No If no, complete waiver section.
Accelerated benefits within the policy may be taxable. You should consult your personal tax advisor to assess the impact of the benefit.

Vision

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

Office use only
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 # Div #

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):

Medical for:	❍ Myself	❍ My spouse / domestic partner	❍ My dependent child(ren)
Dental for:	❍ Myself	❍ My spouse / domestic partner	❍ My dependent child(ren)
Basic Life for:	❍ Myself	❍ My spouse / domestic partner	❍ My dependent child(ren)
Vision for:	❍ Myself	❍ My spouse / domestic partner	❍ My dependent child(ren)
Short Term Disability for:	❍ Myself		
Long Term Disability for:	❍ Myself		
Health Savings Account for:	❍ Myself		
Waive Coverage for Workplace Voluntary Benefits:			
Whole Life for:	❍ Myself	❍ My spouse / domestic partner	❍ My dependent child(ren)
Level Term Life for:	❍ Myself	❍ My spouse / domestic partner	❍ My dependent child(ren)
Critical Illness for:	❍ Myself	❍ My spouse / domestic partner	❍ My dependent child(ren)
Group Lump Sum Cancer for:	❍ Myself	❍ My spouse / domestic partner	❍ My dependent child(ren)
Cancer Expense for:	❍ Myself	❍ My spouse / domestic partner	❍ My dependent child(ren)
Supplemental Health for:	❍ Myself	❍ My spouse / domestic partner	❍ My dependent child(ren)
Accident for:	❍ Myself	❍ My spouse / domestic partner	❍ My dependent child(ren)
Hospital Indemnity for:	❍ Myself	❍ My spouse / domestic partner	❍ My dependent child(ren)
Disability Income Plus for:	❍ Myself		
Disability Income Advantage for:	❍ Myself		

I decline to apply for group coverage because of:

- ❍ Spousal / Domestic partner coverage
- ❍ Medicare supplement
- ❍ Individual coverage
- ❍ Coverage under another carrier's plan provided by my employer / group
- ❍ Other:_____

True and complete acknowledgement

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.
- 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 / domestic partner) 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 / domestic partner) 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 Employee and Individual Application and Enrollment Form for coverage.

HumanaLife Beneficiary Designation

This form needs to be provided to Humana prior to, or at time of claim.

Employee name (please print) _____

Employee social security number _____ Member contract ID _____

Primary beneficiary designation

First and last name_____ Relationship _____

Address of beneficiary_____

City _____ State _____ ZIP code_____ Percentage _____

First and last name_____ Relationship _____

Address of beneficiary_____

City _____ State _____ ZIP code_____ Percentage _____

Secondary beneficiary designation

First and last name_____ Relationship _____

Address of beneficiary_____

City _____ State _____ ZIP code_____ Percentage _____

First and last name_____ Relationship _____

Address of beneficiary_____

City _____ State _____ ZIP code_____ Percentage _____

Employee signature _____ Date signed _____

If two or more primary beneficiaries are named, and you do not list the benefit percentages, proceeds will be paid in equal shares to the named primary beneficiaries who survive you. If no primary beneficiary survives you, proceeds will be paid to the contingent beneficiaries. If no designated beneficiary survives you, the beneficiary will be determined according to the provisions of the group life insurance contract.

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Guidance when you need it most

GN-51363-HL 12/07

- 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 / domestic partner) 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.
- 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 Employee and Individual 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 Employee and Individual Application and Enrollment Form by Humana.
- Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information or misstatements in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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:

- 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.

This authorization shall be valid for 0-two years from the date shown below or until the date your coverage terminates, whichever comes first and I have the right to revoke this authorization at any time by writing to Humana's Privacy Office.

Humana will not require an applicant for coverage or an individual or family member to be the subject of a genetic test or to be subjected to questions relating to genetic information.

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 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

Does the applicant have any existing life or disability insurance policy(s) and/or annuity(s) ❍ N ❍ Y

Employee / Individual or legal representative signature X _____ Date ☐☐ / ☐☐ / ☐☐☐☐

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

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.