Humana Employee Enrollment Application - Dental, Life, Vision, STIP VIRGINIA

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

❍✓ Life, Vision and Short-Term Income Protection plans insured or administered by **Humana Insurance Company.**
Dental plans insured or administered by **HumanaDental Insurance Company**, **Humana Insurance Company or CompBenefits Insurance Company**.

❍ CompBenefits Vision plan insured and administered by **CompBenefits Insurance Company.**

Please print clearly and fill in each applicable circle.

Dental Group number 699947 Benefit number Division 009

Company name Meritek Inc Proposed Effective Date __/__/____

Company city Princeton Junction State NJ

Employee Information

Last name First name MI Date of birth __/__/____

Social Security number Phone number

Gender: ❍ Female ❍ Male Email address

Street address Apt / Suite / PO Box number

City State Zip code County

Language of choice: ✓ English ❍ Spanish

Employment status: Number of hours worked per week Date of full-time hire __/__/____ ✓ Full-time employee ❍ Retiree

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

Dependent Information

Please enter information for each dependent, including spouse, applying for coverage. For additional dependents, copy and attach an additional Dependent Information form.

1. Last name First name MI Date of birth __/__/____

Social Security number Gender: ❍ Female ❍ Male Relationship: ❍ Spouse ❍ Child ❍ Other:

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

2. Last name First name MI Date of birth __/__/____

Social Security number Gender: ❍ Female ❍ Male Relationship: ❍ Spouse ❍ Child ❍ Other:

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

3. Last name First name MI Date of birth __/__/____

Social Security number Gender: ❍ Female ❍ Male Relationship: ❍ Spouse ❍ Child ❍ Other:

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

4. Last name First name MI Date of birth __/__/____

Social Security number Gender: ❍ Female ❍ Male Relationship: ❍ Spouse ❍ Child ❍ Other:

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

5. Last name First name MI Date of birth __/__/____

Social Security number Gender: ❍ Female ❍ Male Relationship: ❍ Spouse ❍ Child ❍ Other:

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

Group Number 699947 | Social Security Number

Dental

Group number 699947 | Benefit number | Class/Division 009

Coverage type: ❍ Employee only ❍ Employee and spouse ❍ Employee and child(ren) ❍ Family ❍ Other

Plan name

Within the past 12 months, have you had any individual or other group dental coverage? ❍ No ❍ Yes Orthodontia coverage? ❍ No ❍ Yes

Effective date _ _ / _ _ / _ _ _ _ Term date _ _ / _ _ / _ _ _ _

Prior coverage type: ❍ Employee only ❍ Employee and spouse ❍ Employee and child(ren) ❍ Family

Basic Life

Group number N/A | Benefit number | Class/Division

Primary beneficiary name | Secondary beneficiary name

Class (employer will provide you with this information if needed) | Annual salary (if applicable) $

Basic dependent life: ❍ No ❍ Yes If no, complete waiver section.

State Notice

PAYMENT FROM AN ACCELERATED DEATH BENEFIT MAY BE TAXABLE. ASSISTANCE SHOULD BE SOUGHT FROM YOUR PERSONAL TAX ADVISOR. WE ARE NOT RESPONSIBLE FOR ANY TAX OR OTHER EFFECTS FROM AN ACCELERATED BENEFIT PAYMENT OR LOSS OF ELIGIBILITY FOR ANY STATE OR FEDERAL PROGRAM.

Voluntary Life

Group number N/A | Benefit number | Class/Division

Do you elect voluntary employee life coverage? ❍ No ❍ Yes Amount (minimum of $15,000) $ Annual salary $

Primary beneficiary name | Secondary beneficiary name

Voluntary dependent life: (available only if employee elects voluntary life coverage) Do you elect voluntary child(ren) life coverage? ❍ No ❍ Yes

Do you elect voluntary spouse life coverage? ❍ No ❍ Yes Amount (minimum of $5,000) $

Vision

Group number N/A | Benefit number | Class/Division

Coverage type: ❍ Employee only ❍ Employee and spouse ❍ Employee and child(ren) ❍ Family ❍ Other

Plan name

Short-Term Income Protection

Do you elect Short-Term Income Protection coverage? ❍ No ❍ Yes Annual salary $

Class (employer will provide if needed)

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. I proclaim that I was not pressured or forced by my employer, 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)

Vision for: ❍ Myself ❍ My spouse ❍ My dependent child(ren)

Basic life for: ❍ Myself ❍ My spouse ❍ My dependent child(ren)

Short-Term Income Protection for: ❍ Myself

I decline to apply for group coverage because of (check all that apply): ❍ Spousal coverage ❍ Medicare supplement ❍ Individual coverage ❍ Coverage under another carrier's plan provided by my employer ❍ Other:

I understand and agree:

- In the event that I should decide to apply for such coverage hereafter, that such subsequent application shall be subject to the applicable terms and conditions of the master group contract(s) or plan provisions as described in the Summary Plan Description 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.
- If I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents provided that I request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.
- Humana reserves the right to delay medical coverage and/or deny life or dental coverage with any future application for coverage.

Group Number 699947 | Social Security Number

Agreement

True and complete acknowledgement

I understand, agree and represent:

- I have read this document or it has been read to me.
- The answers provided within this entire application for coverage are to the best of my knowledge and belief, true and complete.
- Neither my employer nor the agent has the authority to waive a complete answer to any question, determine coverage or insurability, alter any contract, or waive any of the rights and requirements of the company checked below.
- If this application for coverage is accepted, coverage will be effective on the date specified by the company checked below on the certificate of coverage/certificate of insurance.
- Any misrepresentation contained herein relied on by the company checked below may be used to reduce or deny a claim or void the contract within the contestable period if such misrepresentation materially affected the acceptance of the risk.

I hereby enroll for benefits for which I am presently eligible or for which I may become eligible under my employer's group contract(s). If any deductions are required for this coverage, I authorize such deductions from my earnings. I reserve the right to revoke this deduction authorization at any time upon written notice unless I have chosen to use pretax deductions.

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.

Authorization

My dependents and I authorize any physician, medical or health care practitioner, hospital, clinic, veterans administration facility, other medical or medically-related facility, third party administrator, Pharmacy Benefit Manager, insurance, HMO or reinsuring company, the Medical Information Bureau, Inc., employer, the Consumer Reporting Agency or banking and financial institutions having information regarding myself and my dependents, including information concerning, advice, diagnosis, treatment and care of the physical, psychiatric, mental or emotional conditions, drug, substance or alcohol abuse, illness, and copies of all hospital or medical records, non-public personal health information, and any other non-medical information to share any and all such information with the company checked below, 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 the company checked below to determine eligibility for coverage, eligibility for benefits under an existing policy, plan administration, and make claim determinations.
- If you decide not to sign this authorization, the company checked below can not complete your plan enrollment or determine your premium rate due to the inability to obtain the necessary information.
- If selecting the Health Savings Account (HSA), you authorize the company checked below or our banking partners to provide your account number to your employer for the purposes of depositing any contributions.
- Any information obtained will not be released by the company checked below 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, it may be redisclosed by the recipient and the information may not be protected by federal and state privacy requirements.
- A copy of this authorization is available to me or my legal representative upon written request.
- A photographic copy of this authorization shall be as valid as the original.
- This authorization shall be valid for 30 months from the date shown below for eligibility purposes.
- This authorization shall be valid for the length of coverage under the plan in regards to a claim determination.
- I have the right to revoke this authorization at any time:
  - To revoke this authorization, I must do so in writing and send my written revocation to the Privacy Office of the company checked below.
  - The revocation will not apply to information that has already been released in response to this authorization.
  - The revocation will become effective after it is received by the Privacy Office of the company checked below.

Signature - please sign below if enrolling or waiving group coverage

Employee or legal representative signature: _____ Date: _____

Name and relationship of legal representative: _____

Spouse signature: _____ Date: _____

(Only if selecting Life coverage over the guarantee issue amount.)

❍Humana Insurance Company ☑HumanaDental Insurance Company ❍CompBenefits Insurance Company

VIRGINIA DISCLOSURE OF ACCELERATED BENEFITS

If a covered employee is diagnosed with a Terminal Illness or Qualified Covered Condition, the employee may request that an accelerated benefit be paid immediately. The Employee Group Term Life Insurance has no cash surrender or loan values. The amount payable is 50% to a maximum benefit of $50,000.

PAYMENT FROM THIS BENEFIT MAY BE TAXABLE. ASSISTANCE SHOULD BE SOUGHT FROM YOUR PERSONAL TAX ADVISOR. WE ARE NOT RESPONSIBLE FOR ANY TAX OR OTHER EFFECTS FROM AN ACCELERATED BENEFIT PAYMENT OR LOSS OF ELIGIBILITY FOR ANY STATE OR FEDERAL PROGRAM.

EFFECT ON DEATH BENEFIT

Payment of this benefit does not guarantee that the employee's full death benefit will eventually be paid. The employee must still be insured under the Policy at the time of death for the remainder of the Term Life Insurance benefit to be paid.

The amount of Term Life Insurance payable to the beneficiary at the time of death will be reduced by any Accelerated Benefit amount paid. The remaining Term Life Insurance amount will be paid according to the terms and provisions of the Policy. Any amount you could otherwise convert will also be reduced by the Accelerated Benefit.

DEFINITIONS

Terminal Illness means a **Sickness** or **Bodily Injury** which is diagnosed by a **Qualified Practitioner** as life-threatening with a life expectancy of 24 months or less or any condition which requires continuous **Confinement** in a **Qualified Treatment Facility** if the **Employee** is expected to remain there until death.

Qualified Covered Condition means a medical condition that would in the absence of extensive or extraordinary medical treatment, result in a drastically limited life span. Such conditions may include, but are not limited to:

1. Coronary artery disease resulting in an acute infarction;
2. Coronary artery surgery;
3. Permanent neurological deficit resulting from cerebral vascular accident;
4. End Stage Renal Failure; or
5. Acquired Immune Deficiency Syndrome (AIDS).

Activities of Daily Living means Bathing, Continence, Dressing, Eating, Toileting and Transferring where a **Qualified Practitioner** has determined that the **Employee**:

1. Is unable to perform at least two Activities of Daily Living; or
2. Cognitive impairment requires direct supervision by another person during the majority of each day to protect the **Employee's** health and safety.

QUALIFICATIONS FOR ACCELERATED BENEFITS

The Accelerated Benefit provision is effective for a Terminal Illness or Qualified Covered Condition

1. On the effective date of this Policy for a **Bodily Injury**; or
2. Thirty (30) days following the effective date of the Policy for a **Sickness**.

To qualify for the Accelerated Benefit the covered **Employee** must:

1. Provide proof of Terminal Illness or Qualified Covered Condition acceptable to **Us**;
2. Request this benefit in writing on a form acceptable by **Us**; and
3. Provide written consent stating any beneficiary has agreed to payment of the Accelerated Benefit on the **Employee's** behalf.

PLEASE REFER TO THE ACCELERATED BENEFITS PROVISION OF YOUR CERTIFICATE OF INSURANCE TO DETERMINE THE SPECIFIC TERMS AND CONDITIONS OF THIS BENEFIT.