

For office use only

Social Security Number:

**Employee Enrollment Application** **TEXAS**

# Medical (2-50 employees)

Please use black ink and capital letters in each box and fill in each circle where applicable.

Group number (if known)

Benefit number

## Medical plan information

If selecting medical coverage other than employee only, complete and attach the Dependent Information form.

Coverage type:

- Employee only
- Employee and spouse
- Employee and child(ren)
- Family
- Other: \_\_\_\_\_

Plan name

Network name

### HMO and POS only: (not applicable for HumanaAccess HMO)

Employee's primary care physician

Physician ID

Current patient?  No  Yes

### HMO and POS only:

Employee's OBGYN primary care physician (if applicable)

Physician ID

Current patient?  No  Yes

## Prior medical coverage

This section must be completed in order for Humana to process any medical claims.

Within the past 18 months, have you had any individual or other group medical coverage, including Medicare?  No  Yes

Prior medical carrier name

Policy number

Prior carrier phone number

Medicare ID

Effective date (MMDDYYYY)

Termination date (MMDDYYYY)

Level of coverage:  Employee  Employee and spouse  Employee and child(ren)  Family

Still in effect?  No  Yes

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Humana Insurance Company  
Humana Health Plan of Texas, Inc.

**Waiver (refusal of medical coverage)**

I acknowledge that I have been given the opportunity to apply for group medical coverage available to me and my dependents through my employer. I hereby waive medical insurance coverage for (check all that apply):

Myself     My spouse     My dependent child(ren)

I decline to apply for group medical coverage because of:

- Spousal coverage
- Medicare supplement
- Individual medical coverage
- Medical 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.
- In the event that I should decide to apply for HMO or POS coverage hereafter, I will only be eligible at the group's open enrollment period.
- In the event that I should decide to apply for PPO, Classic and Indemnity coverage hereafter, Humana reserves the right to impose a 12-month pre-existing limitation.
- 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, placement for adoption or suit 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, placement for adoption or suit for adoption.