Last name:	First name:

Humana Employee Primary Care Physician/Dentist Selection — WISCONSIN

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

PPO, Classic, and Indemnity Medical plans, Life and Vision plans insured or administered by Humana Insurance Company. Medical HMO plans offered by Humana Wisconsin Health Organization Insurance Corporation. Medical POS plans offered by Humana Wisconsin Health Organization Insurance Corporation and insured or administered by Humana Insurance Company. Dental plans insured or administered by HumanaDental Insurance Company or Humana Insurance Company.

Please print clearly and fill in each applicable circle.

Primary Care Physician/Dentist Selection — WI-72000-PP 4/2008

Relationship	Member Last name, First name MI	Primary care physician name	Physician ID	Current patient?	Primary dentist name	Current patient?
Employee				❍ N ❍ Y		❍ N ❍ Y
Spouse				❍ N ❍ Y		❍ N ❍ Y
Child				❍ N ❍ Y		❍ N ❍ Y
Child				❍ N ❍ Y		❍ N ❍ Y
Child				❍ N ❍ Y		❍ N ❍ Y
Other (specify):				❍ N ❍ Y		❍ N ❍ Y

Humana Employee Enrollment Form - Short-Term Income Protection (STIP) — WISCONSIN

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

Short-Term Income Protection plans insured or administered by Humana Insurance Company.

Please print clearly and fill in each applicable circle.

STIP Group #:	Benefit #:	Class/Div: WI-72000-SP 4/2008
Do you elect Short-Term Income Protection coverage? ❍ N ❍ Y (If no, complete waiver.)	Annual salary $	Class (employer will provide if needed)

Waiver (refusal of coverage) for STIP — WI-72000-WV 4/2008

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 is evidence of this action.

I hereby waive coverage for (check all that apply):
Short-Term Income Protection for: ❍ Myself