Employer Group Application (Dental and Vision - all group sizes)

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The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in this Employer Group Application as "Humana", "We", "Us", or "Our".

☐ Dental plans insured or administered by Humana Insurance Company 1100 Employers Blvd Green Bay, WISCONSIN 54344.
☐ Dental EPO plans insured or administered by Humana Medical Plan of Utah, Inc. 9815 South Monroe Street Suite 300 Sandy, UTAH 84070.
☐ Vision plans insured or administered by Humana Insurance Company 1100 Employers Blvd Green Bay, WISCONSIN 54344.

1. GROUP INFORMATION – Please type or print clearly in black ink

Group number:				
Group name:				Requested effective date __/__/____
Corporate/Situs location street address:	City:	State:	ZIP code:	County:
Date company established (MM/DD/YYYY):	Federal Tax ID:	Nature of business/SIC code:	Phone number:	
Benefit Administrator/management contact name:				
Phone number:	Email address:			
Billing contact name:				
Billing address (N/A if same as street address):	City:	State:	ZIP code:	
Phone number:	Email address:			

Are separate divisions/classes required for billing or reporting? ☐ No ☐ Yes
If yes, please explain. Attach additional signed and dated sheets, if necessary.

2. ELIGIBILITY REQUIREMENTS

Average total number of employees ☐	This means the average number of employees for the preceding calendar year. An employee is typically any person for which the company issues a W-2, regardless of full-time, part-time or seasonal status or whether or not they have medical coverage.
Average number of full-time equivalent employees ☐	For all employees included in the average total number of employees (above), calculate the average number of full-time equivalents for the preceding calendar year. The monthly full-time equivalents are calculated as follows: • number of **full-time employees** (who worked 30 hours or more per week on average); plus • total number of hours worked by **part-time employees** during the month capped at 120 hours, divided by 120.

Eligible employee count (including those employees who waive coverage):	**Dental**	**Vision**

Are you offering coverage to retirees (Dental and Vision)? ☐ No ☐ Yes
Required age (minimum 50): Minimum years of service:
Which plan(s) are you offering? ☐ Medicare + Choice ☐ Other (list plan):_____
Do you wish to offer coverage to dependents of retirees? (Medicare + Choice not available?) ☐No ☐ Yes
Who should receive the premium bill? ☐Employer ☐ Retiree

Number of retirees to be covered:	**Dental:**	**Vision:**

Does this company have any subsidiaries or affiliates, or are there any other associated entities that are eligible to file a federal or state combined tax return? ☐ No ☐ Yes If yes, enter information below:

Company name	**Total employees**

Probationary waiting period for eligible employees: ☐ 0 days ☐ 30 days ☐ 60 days ☐ 90 days ☐ Other: _____
If you prefer months, please select "Other" and specify the number of months.

Employee effective provision (the employee termination date coincides with the effective date provision):
☐ First of the month following probationary waiting period
☐ Immediately following probationary waiting period (required for 90 day probationary waiting period)

Do you want to exclude a class of employees? ☐ No ☐ Yes
If yes, check class to exclude:
☐ Union ☐ Non-union ☐ Hourly ☐ Salary ☐ Management ☐ Non-management ☐ Other:

Is this a Collectively Bargained Plan? ☐ No ☐ Yes Name of plan _____
Plan number (assigned by employer for use in filing IRS form 5500):

Has this Group been insured by Humana within the last three years? ☐ No ☐ Yes
If yes, provide prior Group number: Termination date:

Do you wish to offer Domestic Partner coverage? ☐ No ☐ Yes

3. COBRA/STATE CONTINUATION

Is your Group subject to: COBRA ☐ No ☐ Yes State Continuation ☐ No ☐ Yes

Are any present or former employees/dependent currently on or eligible to elect COBRA/State Continuation? ☐ No ☐ Yes
If yes, enter information below. Attach additional signed and dated sheets (reorder UT-52660), if necessary.

Name of applicant	Qualifying event (e.g. termination of employment, divorce, etc)	Indicate if the applicant is currently on COBRA or State Continuation	COBRA/State Continuation			Lines of coverage (select all that apply)	
			Qualifying event date	Start date	End date	Dental	Vision
		☐ COBRA ☐ State Continuation				☐	☐
		☐ COBRA ☐ State Continuation				☐	☐
		☐ COBRA ☐ State Continuation				☐	☐
		☐ COBRA ☐ State Continuation				☐	☐

Plan Selection – Please review the Regulatory Pre-enrollment Disclosure Guide with your agent, broker or producer. Complete the quote number and reference number (if applicable) to indicate the plans elected.

4. DENTAL PLAN SELECTION ☐ Electing ☐ Not electing

Sold quote number: _____
Plan 1 name _____ / Reference # _____
Plan 2 name _____ / Reference # _____
Plan 3 name _____ / Reference # _____
Attach additional signed and dated sheets (reorder UT-52659), if necessary.

EMPLOYER CONTRIBUTION (Percentage or dollar amount): Minimum employer contribution toward employee premium is [0]% or $[0].
Employee: Employee/Spouse: Employee/Child: Family:

Participation - Available to employers with 1 or more enrolled employees and • Non-Contributory plan – 100% • Contributory plan – 50% • Voluntary plan – minimum of 2 enrolled	Number of employees waiving with other qualifying coverage:	Number of employees waiving without other qualifying coverage:	Number of employees enrolled:

CURRENT CARRIER
Is this Group transferring group dental coverage from another group carrier? ☐ No ☐ Yes
Does prior coverage include orthodontia? ☐ No ☐ Yes
If yes, provide carrier name: _____ Proposed termination date:_____

5. VISION PLAN SELECTION ☐ Electing ☐ Not electing

Sold quote number: _____
Plan 1 name _____ / Reference # _____
Plan 2 name _____ / Reference # _____
Dual choice arrangements are subject to underwriting review.

EMPLOYER CONTRIBUTION (Percentage or dollar amount): Minimum employer contribution toward employee premium is is [0]% or $[0]. Employee: Employee/Spouse: Employee/Child: Family:			
Participation - Available to employers with: • 1 or more enrolled employees when sold with medical and/or dental; • 5 or more enrolled when standalone; and • Non-Contributory plan – 100% • Contributory plan – 50% • Voluntary plan – minimum of 5 enrolled	Number of employees waiving with other qualifying coverage:	Number of employees waiving without other qualifying coverage:	Number of employees enrolled:

If electing:

- Life, please complete form # UT-52657-LIFE.
- Medical (1-50 employees), please complete the UT universal employee application.
- Medical (51+ employees), please complete form # UT-52657-MED.

6. THE FOLLOWING APPLIES TO ALL GROUPS SUBJECT TO ERISA

Benefits under this plan will be paid only if (the plan administrator) decides in its discretion that (the claimant) is entitled to them. (The plan administrator) also has discretion to determine eligibility for benefits and to interpret the terms and conditions of the benefit plan. Determinations made by (the plan administrator) pursuant to this reservation of discretion do not prohibit or prevent a claimant from seeking judicial review in federal court of (the plan administrator's) determinations.

The reservation of discretion made under this provision only establishes the scope of review that a federal court will apply when (a claimant) seeks judicial review of (the plan administrator's) determination of eligibility for benefits, the payment of benefits, or interpretation of the terms and conditions applicable to the benefit plan.

(The plan administrator) is an insurance company that provides insurance to this benefit plan and the federal court will determine the level of discretion that it will accord (the plan administrator's) determinations.

You, the participating employer, policyholder, contract holder, or Certificate sponsor, intend to establish, sponsor, plan sponsor and endorse an employee benefit plan which will be governed by ERISA. You are the ERISA plan administrator.

7. THE FOLLOWING APPLIES TO ALL GROUPS

The Group is only eligible if a bona fide business entity exists.

If you fail to pay premium when due, coverage may be subject to termination as specified under the terms of the Policy. You understand and agree that your coverage is continued monthly subject to timely payment of premium. We reserve the right to change the premium rates on any premium due date, as permitted by applicable law. You will receive advance written notice.

You will provide information or records upon request that We determine are relevant to this Employer Group Application and group coverage for inspection by Us or Our representative. For you to remain eligible you must meet the eligibility, participation and contribution requirements for each respective coverage at all times.

We have the right to use information provided by you to determine whether this Employer Group Application will be accepted or declined and to establish appropriate premiums.

Humana reserves the right to recalculate the rates based on final enrollment/participation.

8. AGREEMENT AND SIGNATURE – Review your policy/certificate carefully

You, the authorized representative of the Group named herein, understand, agree and represent: You have read this Employer Group Application and the information you provided is accurate and complete and can be substantiated by your records. You have received and reviewed the applicable regulatory information and the Humana issued proposal. You referred to the proposal to select the benefit plan(s) applied for in this Employer Group Application and confirmed your selection from the Humana issued proposal before signing below. By executing this Employer Group Application, you agree to its terms and represent and warrant that you shall comply with the terms of the Policy and all applicable laws. 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. We shall rely on your representations and any information submitted by you or on your behalf. Providing incomplete, inaccurate or untimely information may reduce an individual's or Group's coverage or may increase past premium. A person that knowingly presents false information in an application for insurance or a viatical settlement is guilty of a crime and may be subject to fines and confinement in prison.

Coverage is not in effect unless and until you receive written notification from Us. The Employer Group Application will form part of any contract or coverage issued. The policy/certificate provides limited benefits. Review your policy/certificate carefully. 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. Neither you nor the agent has the authority to waive a complete answer to any question, determine coverage or insurability, alter any contract, bind Us by making any promise or representation, or waive any of Our other rights or requirements. No waiver or change will bind Us unless signed by an authorized officer of Our company.

DO NOT CANCEL ANY CURRENT GROUP COVERAGE UNTIL YOU RECEIVE WRITTEN NOTICE FROM US THAT WE HAVE ISSUED COVERAGE.

Dated on: _____ by: _____
(month, day, year) (Printed name of authorized representative of Group)

Signature:_____ Title: _____

9. AGENT INFORMATION

Agency of Record (for commissions and correspondence)	**Agent/Agency of Record** (for split commissions)
Name (print or type)	Name (print or type)
Tax ID/Social Security Number/Humana Agent Number	Tax ID/Social Security Number/Humana Agent Number
Commission split ☐ No ☐ Yes If yes, percentage: _____ (equals 100%)	Commission split ☐ No ☐ Yes If yes, percentage: _____ (equals 100%)
Writing Agent/Broker Producer	**Agent/Agency of Record**
Name (print or type)	Name (print or type)
Tax ID/Social Security Number/Humana Agent Number	Tax ID/Social Security Number/Humana Agent Number
Commission split ☐ No ☐ Yes If yes, percentage: _____ (equals 100%)	Commission split ☐ No ☐ Yes If yes, percentage: _____ (equals 100%)

General Agency (Complete only if agency involved in sale)

General agency information pertains to: ☐ Agency of Record ☐ Writing Agent	
Name (print or type)	Tax ID/Social Security Number/Humana Agent Number

As the Agent, I acknowledge that I am responsible to meet with the Group submitting this Employer Group Application in order to fully and accurately represent the terms and conditions of the plans and services of the offering or insuring entity, or one of its subsidiaries. These provisions are available to me and the Group in the Regulatory Pre-enrollment Disclosure Guide or other plan literature. Additionally, I acknowledge that I am responsible for providing the Group a copy of their completed and signed Employer Group Application.

Writing Agent signature: _____ Date: _____

• Humana Insurance Company, 1100 Employers Blvd., Green Bay, WI 54344
• Humana Medical Plan of Utah, Inc., 9815 S. Monroe Street, Ste. 300, Sandy, UT 84070