Employer Group Application (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, Vision, Life, and Disability plans insured or administered by Humana Insurance Company.

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

Eligible employee count (including those employees who waive coverage):	**Dental**	**Vision**	**Life**	**Short Term Disability**	**Long Term Disability**

Are you offering coverage to retirees (Dental and Vision)? ☐ No ☐ Yes
Required age (minimum 50): Minimum years of service:

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**

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

Probationary Waiting Period
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.

Probationary Waiting Period
For STD, LTD groups of 100+ Eligible employees only: Does the probationary waiting period apply uniformly to all classes of employee?
☐ Yes (indicate "all" as Class Name in #1) ☐ No (indicate the class name and waiting period per class (if more than 4, add additional pages).

1. Class Name _____
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.

2. Class Name_____
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.

3. Class Name_____
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.

4. Class Name_____
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.

Effective Date Provision
Employee effective provision:
☐ First of the month following probationary waiting period
☐ Immediately following probationary waiting period (required for 90 day probationary waiting period)
The employee termination date coincides with the effective date provision
For STD, LTD, Life, the employee termination date is the last day of employment

3. COBRA

Is your Group subject to: COBRA ☐ No ☐ Yes

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

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

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 ME-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 0% or $0.
Employee: Employee/Spouse: Employee/Child: Family:

Participation - Available to employers with: • 1 or more enrolled employees when sold with 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:

6. LIFE PLAN SELECTION

Sold quote number: _____ Reference # _____

Basic Life and AD&D: ☐ Electing ☐ Not electing -OR- **Basic Life ONLY:** ☐ Electing ☐ Not electing

EMPLOYER CONTRIBUTION (Percentage or dollar amount) for **BASIC** Employee and Dependent Life **ONLY**): Minimum employer contribution toward employee premium is 0% or $0.

Employee: Employee/Spouse: Employee/Child: Family:

Participation Requirement - Available to employers with two or more enrolled employees.
• Non-contributory plan - 100% • Contributory plan - 50%

Number of hours worked per week to be eligible (select between 20 and 40 hours, or if other please specify):

CURRENT CARRIER
Is this Group transferring group life coverage from another group carrier?: ☐ No ☐ Yes

If yes, provide carrier name: Proposed termination date:

As of the date of this application, list any employees currently disabled and not actively at work (attach additional signed and dated pages, if necessary):

Rate Guarantee: ☐ 2 Year ☐ 3 Year
Age Reduction Schedule: ☐ Schedule 1 ☐ Schedule 2 ☐ Schedule 3 ☐ Other (as quoted)
☐ Flat amount $ _____
☐ Salary plan – options are 1x to 7x salary (in .5 increments), rounded to the next highest $1,000
Salary level: ____ x salary Maximum benefit: $_____
☐ Class schedule (complete the table below)

Class	Description	Flat amount or Salary level
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

Basic Dependent Life: ☐ Electing ☐ Not electing
If yes, indicate volume amount ☐ $20,000/ $10,000 ☐ $10,000/ $10,000 ☐ $10,000/$2,500
☐ $20,000/ $5,000 ☐ $10,000/ $5,000 ☐ $5,000/$1,000

Voluntary Employee Life: ☐ Electing ☐ Not electing Reference # _____
Available to employers with five or more or 25% of the eligible employees enrolled, whichever is greater.

Do you want AD&D? ☐ Electing ☐ Not Electing
Rate Guarantee: ☐ 2 Year ☐ 3 Year
Age Reduction Schedule: ☐ Schedule 1 ☐ Schedule 2 ☐ Schedule 3 ☐ Other (as quoted)

☐ Minimum amount $_____ ☐ Maximum benefit $_____

Voluntary Dependent Life (only available if Employee Voluntary Life is elected): ☐ Electing ☐ Not Electing
Dependent Child Voluntary Amount ☐ $5,000 ☐ $10,000

Please Note: Death benefits under life insurance plans may be variable or fixed under specified conditions. Cash values under life plans may increase or decrease in accordance with the experience of the separate account (subject to any specified minimum guarantees).

7. SHORT-TERM DISABILITY (STD) PLAN SELECTION ☐ Electing ☐ Not electing

Sold quote number: _____
Class 1 name _____ / Reference # _____
Class 2 name _____ / Reference # _____
Class 3 name _____ / Reference # _____
Class 4 name _____ / Reference # _____

Number of hours worked per week to be eligible (select between 20 and 40 hours, or if other please specify):

CURRENT CARRIER
Is this group transferring group disability coverage from another group carrier? ☐ Yes ☐ No
If yes, provide carrier name: _____ Proposed termination date:_____

8. LONG-TERM DISABILITY (LTD) PLAN SELECTION ☐ Electing ☐ Not electing

Sold quote number: _____
Class 1 name _____ / Reference # _____
Class 2 name _____ / Reference # _____
Class 3 name _____ / Reference # _____
Class 4 name _____ / Reference # _____

Number of hours worked per week to be eligible (select between 20 and 40 hours, or if other please specify):

CURRENT CARRIER
Is this group transferring group disability coverage from another group carrier? ☐ Yes ☐ No
If yes, provide carrier name: _____ Proposed termination date:_____

9. COMPLETE BELOW IF SELECTED *EITHER* SHORT-TERM OR LONG-TERM DISABILITY

As of the date of this application, list any employees currently disabled and not actively at work (attach additional signed and dated pages, if necessary):

W-2 services option for Short-Term Disability (please choose one):

☐ Option 1: Withhold state and federal income taxes and the employee's portion of FICA. Prepare and file W-2 forms.

☐ Option 2: Withhold state and federal income taxes and the employee's portion of FICA. Applicant waives W-2 forms services.

A detailed description of the W-2 services elected by applicant pursuant to this application will be provided to the applicant. Such services will be performed in accordance with the above election and established as standard procedures.

W-2 services option for Long-Term Disability (please choose one):

☐ Option 1: Withhold state and federal income taxes and the employee's portion of FICA. Prepare and file W-2 forms.

☐ Option 2: Withhold state and federal income taxes and the employee's portion of FICA. Applicant waives W-2 forms services.

A detailed description of the W-2 services elected by applicant pursuant to this application will be provided to the applicant. Such services will be performed in accordance with the above election and established as standard procedures.

10. THE FOLLOWING APPLIES TO ALL GROUPS SUBJECT TO ERISA

As claims administrator with authority to make claim determinations as described in Section 503 of the Employee Retirement Income Security Act (ERISA), We make final decisions under the Policy or Group Plan with respect to determining eligibility for coverage and paying claims for benefits, including deciding appeals of denied claims. As claims administrator, We shall have authority to: 1) interpret Policy or Group Plan provisions; 2) make decisions regarding eligibility for coverage and benefits; and 3) resolve factual questions relating to coverage and benefits.

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.

11. 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.

12. ELECTRONIC DELIVERY

By signing this Employer Group Application, you, the authorized representative of the Group, consent to the electronic delivery of contractual documents to you including, but not limited to, the policy and certificate. These documents are accessed through the secure employer section of the Humana.com website. At any time, you may contact Humana at 1-800-232-2006 to obtain a mailed paper copy of any document.

13. 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. It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

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 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.

DENTAL PLANS: The policy provides dental benefits only. Review your policy carefully.

VISION PLANS: The policy provides vision benefits only. Review your policy carefully.

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

Signature:_____ Title:_____

14. 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: _____