Employer Group Application (all group sizes)

Humana®

MINNESOTA

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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".

☐ Life plans insured or administered by Humana Insurance Company.
☐ Dental plans insured or administered by Humana Insurance Company.
☐ Vision plans insured or administered by Humana Insurance Company.
☐ 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, and 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 MN-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 MN-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

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 full and exclusive discretionary 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. 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 who submits an application or files a claim with intent to defraud or help commit a fraud against an insurer is guilty of a crime.

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.

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

Signature:_____ Title: _____

13. 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: _____

NOTICE CONCERNING POLICYHOLDER RIGHTS IN AN INSOLVENCY UNDER THE MINNESOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION LAW

If the insurer that issued your life, annuity, or health insurance policy becomes impaired or insolvent, you are entitled to compensation for your policy from the assets of that insurer. The amount you recover will depend on the financial condition of the insurer.

In addition, residents of Minnesota who purchase life insurance, annuities, or health insurance from insurance companies authorized to do business in Minnesota are protected, SUBJECT TO LIMITS AND EXCLUSIONS, in the event the insurer becomes financially impaired or insolvent. This protection is provided by the Minnesota Life and Health Insurance Guaranty Association.

MINNESOTA LIFE & HEALTH INSURANCE GUARANTY ASSOCIATION
3300 WELLS FARGO CENTER
90 SOUTH 7TH STREET
MINNEAPOLIS, MN 55402
Phone: 612.322.8713 Fax: 402.474.5393

The maximum amount the Guaranty Association will pay for all policies issued on one life by the same insurer is limited to $500,000. Subject to this $500,000 limit, the guaranty association will pay up to $500,000 in life insurance death benefits, $130,000 in net cash surrender and net cash withdrawal values for life insurance, $500,000 in health insurance benefits, including any net cash surrender and net cash withdrawal values, $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values, $410,000 in present value of annuity benefits for annuities which are part of a structured settlement or for annuities in regard to which periodic annuity benefits, for a period of not less than the annuitant's lifetime or for a period certain of not less than ten years, have begun to be paid on or before the date of impairment or insolvency, or if no coverage limit has been specified for a covered policy or benefit, the coverage limit shall be $500,000 in present value. Unallocated annuity contracts issued to retirement plans, other than defined benefit plans, established under section 401, 403 (b), or 457 of the Internal Revenue Code of 1986, as amended through December 31, 1992, are covered up to $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values, for Minnesota residents covered by the plan provided, however, that the association shall not be responsible for more than $10,000,000 in claims from all Minnesota residents covered by the plan. If total claims exceed $10,000,000 the $10,000,000 shall be prorated among all claimants. These are the maximum claim amounts. Coverage by the Guaranty Association is also subject to other substantial limitations and exclusions and requires continued residency in Minnesota. If your claim exceeds the Guaranty Associations limits you may still recover a part or all of that amount from the proceeds of the liquidation of the insolvent insurer, if any exist. Funds to pay claims may not be immediately available. The Guaranty Association assesses insurers licensed to sell life and health insurance in Minnesota. After the insolvency occurs claims are paid from this assessment.

THE COVERAGE PROVIDED BY THE GUARANTY ASSOCIATION IS NOT A SUBSTITUTE FOR USING CARE IN SELECTING INSURANCE COMPANIES THAT ARE WELL MANAGED AND FINANCIALLY STABLE. IN SELECTING AN INSURANCE COMPANY OR POLICY, YOU ARE ADVISED NOT TO RELY ON COVERAGE BY THE GUARANTY ASSOCIATION.

THIS NOTICE IS REQUIRED BY MINNESOTA STATE LAW TO ADVISE POLICYHOLDERS OF LIFE, ANNUITY OR HEALTH INSURANCE POLICIES OF THEIR RIGHTS IN THE EVENT THEIR INSURANCE CARRIER BECOMES FINANCIALLY IMPAIRED OR INSOLVENT. THIS NOTICE IN NO WAY IMPLIES THAT THE COMPANY CURRENTLY HAS ANY TYPE OF FINANCIAL PROBLEMS. ALL LIFE, ANNUITY AND HEALTH INSURANCE POLICIES ARE REQUIRED TO PROVIDE THIS NOTICE.

I have read the foregoing notice and received a copy for my records this_____ day of _____, 20_____.

_____
Applicant

A person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

MINNESOTA DISCLOSURE OF ACCELERATED BENEFITS

If a covered employee is diagnosed with a Terminal 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 $250,000 in the present value, including net cash surrender and net cash withdrawal values. Payment will be made in one lump sum to You and is payable once during Your lifetime. The amount requested must be at least $5,000.

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 Death 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 Death Benefit.

DEFINITIONS

Accelerated benefits means benefits payable under the life insurance contract:

1. to a certificate holder, during the lifetime of the insured, in the anticipation of death or upon the occurrence of a specified life-threatening or catastrophic condition as defined by the policy or rider;
2. that reduce the death benefit otherwise payable under the life insurance contract; and
3. that are payable upon the occurrence of a single qualifying event that results in the payment of a benefit amount fixed at the time of acceleration.

Qualifying event means one or more of the following:

1. a medical condition that would result in a drastically limited life span as specified in the contract;
2. a medical condition that has required or requires extraordinary medical intervention, such as, but not limited to, major organ transplant or continuous artificial life support without which the insured would die;
3. a condition that usually requires continuous confinement in an eligible institution as defined in the contract if the insured is expected to remain there for the rest of the insured's life;
4. 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, one or more of the following:
   A. coronary artery disease resulting in an acute infarction or requiring surgery;
   B. permanent neurological deficit resulting from cerebral vascular accident;
   C. end stage renal failure;
   D. Acquired Immune Deficiency Syndrome; or
   E. other medical conditions that the commissioner shall approve; or
   F. other qualifying events that the commissioner approves.

Terminal Condition means a **Sickness** or **Bodily Injury** which is diagnosed by a **Qualified Practitioner** which:

1. Is life-threatening with a life expectancy of 24 months or less;
2. Requires the **Employee** to be continuously confined in a **Qualified Treatment Facility** for the rest of his or her life; or
3. Requires extraordinary medical intervention, without which the Employee's life span would be drastically limited or he or she would not live, such conditions may include, but are not limited to:
   A. Coronary artery disease resulting in acute infarction;
   B. Coronary artery surgery;
   C. Permanent neurological deficit resulting from cerebral vascular accident;
   D. End Stage Renal failure; or
   E. Acquired Immune Deficiency Syndrome (AIDS)

QUALIFICATIONS FOR ACCELERATED BENEFITS

The Accelerated Death 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 Accidents**: or
2. Thirty (30) days following the effective date of this Policy for a **Sickness**.

To qualify for the Accelerated Death Benefit the covered employee must:

1. Provide proof of a Terminal Illness acceptable to us;
2. Request this benefit in writing on a form acceptable by us; and
3. Provide written consent stating assignee or irrevocable beneficiary has agreed to payment of the Accelerated Death Benefit on the employee's behalf.

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