Group Maintenance Request

ARKANSAS

We, us, our and Humana refer to the insuring entities listed on the Employer Group Application.

GROUP INFORMATION

Company name:	Group Number:	Proposed effective date for change: / /
Provide e-mail address to receive confirmation e-mails when this request is received and completed:		

PLAN SELECTION - To complete this information, refer to your proposal. Attach additional signed and dated sheets (reorder AR-52659), if necessary.

Add: Indicate the Plan Name, Quote #, and Reference # of the plan(s) to add.
Replace: Indicate the Plan Name, Quote #, and Reference # of the plan(s) to add and the Plan name or description for the plan being replaced.
Term: Indicate the Plan Name or description of the plan to terminate or if terminating all plans, select the appropriate option below.

DENTAL PLAN SELECTION

☐ Add ☐ Replace ☐ Term	Add: Plan Name _____ Quote # _____ Ref # _____ Term/Replace: Plan Name_____
☐ Add ☐ Replace ☐ Term	Add: Plan Name _____ Quote # _____ Ref # _____ Term/Replace: Plan Name_____
☐ Add ☐ Replace ☐ Term	Add: Plan Name _____ Quote # _____ Ref # _____ Term/Replace: Plan Name_____

Additional Rider(s):

☐ Term All DENTAL Plan(s)

If DENTAL is a new line of Business with Humana: Prior group carrier? ☐ Yes ☐ No Include ortho? ☐ Yes ☐ No
Prior Carrier Name: _____ Term date: / /

If DENTAL is a new line of business with Humana complete:	Number of employees waiving with other qualifying coverage:	Number of employees waiving without other qualifying coverage:	Number of employees enrolling:

VISION PLAN SELECTION

☐ Add ☐ Replace ☐ Term	Add: Plan Name _____ Quote # _____ Ref # _____ Term/Replace: Plan Name_____
☐ Add ☐ Replace ☐ Term	Add: Plan Name _____ Quote # _____ Ref # _____ Term/Replace: Plan Name_____

Additional Rider(s):

☐ Term All VISION Plan(s)

If VISION is a new line of business with Humana complete:	Number of employees waiving with other qualifying coverage:	Number of employees waiving without other qualifying coverage:	Number of employees enrolling:

GROUP INFORMATION

Company name:	Group Number:	Proposed effective date for change: / /
Provide e-mail address to receive confirmation e-mails when this request is received and completed:		

LIFE PLAN SELECTION

BASIC EMPLOYEE LIFE	☐ Add ☐ Replace	Add: Plan Name _____ Quote # _____ Ref # _____	
		Basic Dependent Life (if electing, select one):	☐ $20,000/$5,000 ☐ $10,000/$2,500 ☐ $5,000/$1,000 ☐ $20,000/$10,000 ☐ $10,000/$10,000 ☐ $10,000/$5,000
	☐ Term BASIC LIFE Plan		
If BASIC LIFE is a new line of Business with Humana: Hourly requirement: _____ Contribution: Employee ____%			
VOLUNTARY EMPLOYEE LIFE	☐ Add ☐ Replace	Add: Plan Name _____ Quote # _____ Ref # _____ Voluntary Dependent Life: ☐ $10,000 ☐ $5,000	
	☐ Term VOLUNTARY LIFE Plan		

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

☐ Add ☐ Replace ☐ Term	Add: Class Name _____ Quote # _____ Ref # _____ Term/Replace: Class Name_____
☐ Add ☐ Replace ☐ Term	Add: Class Name _____ Quote # _____ Ref # _____ Term/Replace: Class Name_____
☐ Add ☐ Replace ☐ Term	Add: Class Name _____ Quote # _____ Ref # _____ Term/Replace: Class Name_____
☐ Add ☐ Replace ☐ Term	Add: Class Name _____ Quote # _____ Ref # _____ Term/Replace: Class Name_____
☐ Term All SHORT-TERM DISABILITY Plan(s)	
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:_____	

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

☐ Add ☐ Replace ☐ Term	Add: Class Name _____ Quote # _____ Ref # _____ Term/Replace: Class Name_____
☐ Add ☐ Replace ☐ Term	Add: Class Name _____ Quote # _____ Ref # _____ Term/Replace: Class Name_____
☐ Add ☐ Replace ☐ Term	Add: Class Name _____ Quote # _____ Ref # _____ Term/Replace: Class Name_____
☐ Add ☐ Replace ☐ Term	Add: Class Name _____ Quote # _____ Ref # _____ Term/Replace: Class Name_____
☐ Term All LONG-TERM DISABILITY Plan(s)	
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:_____	

COMPLETE BELOW IF SELECTED *EITHER* SHORT-TERM (STD) OR LONG-TERM DISABILITY (LTD)

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.

EMPLOYEE ELIGIBILITY

Probationary waiting period for eligible employees (applies to all products):
☐ 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 (applies to all products):
☐ First of the month following probationary waiting period
☐ Immediately following probationary waiting period (required for 90 day probationary waiting period)
For Dental and Vision, the employee termination date coincides with the effective date provision.
For Life, the employee termination date is the last date of employment.

OTHER CHANGES

☐ Term ALL HUMANA Plan(s)

Other:

AGREEMENT AND SIGNATURE

By signing this Group Maintenance Request (Request), you are requesting the identified plan change(s) and you fully understand that the Request will have no effect unless and until it is approved in writing by us. We will send written confirmation of the Request which may modify your original request. The confirmation will include the effective date of the change(s), which may be later than the effective date requested. All terms and conditions of the plan not expressly stated in the confirmation remain in effect.

You further understand and agree to comply with all coverage requirements and plan provisions, including underwriting and participation requirements. Payment of premiums on and after the effective date of the change(s) will indicate your agreement to the terms in the confirmation. If you do not wish to accept the change(s) as described in the confirmation, you must provide us written notice of this within 31 days of the date of our confirmation. Coverage is not in effect unless and until you receive written notification from us.

By: _____ _____ _____
Group Authorized Representative (Printed name) (Signature) (Date)

Agent/Agency of Record name:	Humana Agent/Tax ID Number:

I am submitting this request at the specific/express direction of the employer.

Agent signature: _____ Date: _____