

# New Sold Case Checklist

**HUMANA**  
Guidance when you need it most

DALLAS MARKET OFFICE

Group Name \_\_\_\_\_ Quote # \_\_\_\_\_

## Agency/Agent Information

- |   |  |
|---|--|
| <input type="checkbox"/> Contact Name         | <input type="checkbox"/> Leaders Club Agent    |
| <input type="checkbox"/> Contact Phone Number | <input type="checkbox"/> Contact Email Address |

## New Sold Submission

- First Month Premium - **ACH Form** or Check
    - If check, send copy of check with sold package
    - Mail original to shipping address below
    - For email submission, label file as **ACH or CHECK**

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  - Employer Group Application
    - Business Profile Page
    - Plan Selection Page
    - For email submission, label file as **EGA**

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  - Copy of Sold Quote (circle plans sold)
    - For email submission, label file as **QUOTE**

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  - Employee Applications (alphabetical order including waivers)
    - For waivers, please make sure the reason for waiving coverage is noted
    - For email submission, label file as **EE APPS**

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  - Eligibility Information
    - Most Recent Quarterly Wage and Tax
    - Prior carrier bill with employee name and dependent information
    - Eligibility Certification form for employees not listed on the Wage and Tax
    - For email submission, label file as **ELIGIBILITY**

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  - Eligible for Case Discounts? If so, please indicate:**  
**SB80**  
**Discount?** Yes No 3% discount on base plan when employer pays 100% of employee premium and 100% of eligible employees participate (Excl. of Valid Waivers)
- Bundling**  
**Discount?** Yes No Lines Sold - Med Dental Life Vol Life Vision STD LTD Other

## Contact Information

Email New Sold Case documents to:

> [Sbsales@humana.com](mailto:Sbsales@humana.com)

> CC: [vroberts@humana.com](mailto:vroberts@humana.com)

Send Missing Info:

> [newbusinessteam@humana.com](mailto:newbusinessteam@humana.com)

**Vicki Roberts-Small Group Sales Exec**

Phone: 972-643-1784 - Cell: 214-402-8467

Email: [vroberts@humana.com](mailto:vroberts@humana.com)

**Team Partner- Dale Heiking- Sales Rep**

Phone: 1-866-600-8925

Email: [dheiking1@humana.com](mailto:dheiking1@humana.com)

**Shipping Address for checks:**

1600 Aspen Commons  
Suite 600  
Middleton, WI 53562

# Automated Clearing House (ACH) Authorization

## ACH Authorization Agreement For A One-time Payment Upon New Case Installation

Your company (hereinafter "Group") hereby agrees to allow Humana to initiate payment from Group consistent with the following:

1. The ACH payment will be pulled from the financial institution and account number authorized below in the amount of an approximation of the first month's premium payment, as acknowledged by the Group.
2. Payment shall be considered made when Humana initiates the ACH payment transaction from your company's financial institution upon completion of Group setup. If for some reason this payment is unable to be drafted, you will be contacted to authorize a new payment.
3. The initial ACH payment may be terminated by the Group by providing notification to the Sales Office prior to completion of Group setup. If notification is not received until after Group setup has been completed, a refund will be processed.

## Group Information

Employer Legal Business Name

Street Address

City

State

Zip Code

## Financial Institution Information

Name of Group's Financial Institution

Amount \$  
(approximate first month's premium)

Street Address

City

State

Zip Code

Nine-digit American Banker's Association (ABA) Identifying Number for Routing the Transfer of Funds

Account Name to be credited with payments

*Name on the account must match name of Group with which Humana is doing business.*

Account Number

## ACH Authorization Agreement For Recurring Premium Payment

1. Accounts set up for a Recurring Payment will have the 'Total Amount Due' for an invoice charged to the selected account each month on the Scheduled Date. Monthly charges for the 'Total Amount Due' will continue indefinitely unless a Specified End Date or a Fixed Number of Payments is selected.
2. If coverage is terminated prior to the Recurring Payment Schedule Date but an invoice is still unpaid, a charge WILL be made to the selected account for the 'Total Amount Due'. If this results in an overpayment on the account, a refund will be promptly issued.
3. The first recurring payment will occur on the selected debit date after your next invoice is generated. A recurring payment does not become effective until your next billing cycle.

## Recurring Payment Schedule

- By checking you agree to the Recurring Payment Schedule defined below.**

**Amount:** 'Total Amount Due' from invoice. Amount can be verified on invoice or online at Humana.com.

**Payment Date:** Day \_\_\_\_\_ of every month. Date elected must be between 1st and 10th.

**Effective Period (select one):**  Until Cancelled  For \_\_\_\_\_ payments  Until Date \_\_\_\_\_ (MM/DD/YYYY)

*Group is responsible for management of the Recurring Payment Schedule by registering at Humana.com or by contacting their designated billing representative.*

## Signature

**Group's Authorizing Official:** By signing this document, you authorize Humana to initiate an ACH payment(s) from the above company as requested by the Group. This includes authorization for a one-time payment upon new case installation, and/or recurring payment(s) as requested in the Recurring Payment Schedule above.

Signature

Date

Printed Name

Phone number

Title

# Eligibility Certification Form

This Eligibility Certification form and your most recent state wage and tax report (State Quarterly Report) will be used by Humana to determine if your company and employees satisfy your plan's participation and eligibility requirements.

**Employer details**

Employer name \_\_\_\_\_

Renewal date \_\_\_\_\_

Group number \_\_\_\_\_

Employer address \_\_\_\_\_

**Employee name**

Please list below all individuals who meet the following conditions, regardless of whether they are to be considered for coverage under your group plan.

- Not listed on your most recent state wage and tax report, AND
  - Actively working for you OR
  - Not working, but currently covered on your group plan for any reason (i.e. state or federal continuation, disability, etc)

**Status code**

Please use the following letter codes to indicate status

- |   |  |   |
|---|--|---|
| <b>SP</b> Sole proprietor (maximum of one person from this category may be eligible for coverage). Must be actively employed at this company. | <b>PAR</b> Partner. Must be actively employed at this company.                 | <b>TD</b> Totally disabled  |
| <b>OWN</b> Owner, not a sole proprietor. Must be actively employed at this company.   | <b>FT</b> Full-time  | <b>RE</b> Retired Employee  |
|   | <b>PT</b> Part-time  | <b>CO</b> Covered through state or federal continuation of coverage (COBRA) |
|   | <b>TM</b> Temporary or seasonal employee (working less than 48 weeks per year) | <b>WP</b> Waiting period  |

**How paid**

- |                 |                                   |  |
|-----------------|-----------------------------------|--|
| <b>H</b> Hourly | <b>L</b> Leased                   | <b>O</b> Other (please specify)  |
| <b>S</b> Salary | <b>CO</b> Commissioned/contracted | <b>NA</b> Not applicable (i.e. COBRA, retired, totally disabled, etc.) |

Employee name	Date of employment	Hours worked per week	Status code	How paid
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

If additional space is needed, please attach additional pages. Additional pages must be signed and dated.

A waiver form will be required for employees and their dependents who are waiving any of the coverages available under your plan.

- I hereby certify that I have read this document and that the information provided is accurate and complete.
- I certify that all employees actively working for me are compensated in a manner that complies with all applicable federal and state minimum wage requirements.
- I certify that the information provided can be substantiated by business documents. Upon request, I agree to provide the documentation requested to establish eligibility and that participation requirements are met at all times coverage is provided by Humana (i.e. Wage and Tax form, Taxpayer I.D. numbers, W-2 forms, etc.)
- I understand that providing incomplete, inaccurate or untimely information may void, reduce or terminate any individual or group coverage or result in an increase in premium.

Signature of Employer \_\_\_\_\_  
 (Owner, Officer, Partner)

Date \_\_\_\_\_

Print name of Employer \_\_\_\_\_

Title \_\_\_\_\_

Employer name: \_\_\_\_\_

Employee name	Date of employment	Hours worked per week	Status code	How paid
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				
21				
22				
23				
24				
25				
26				
27				
28				
29				
30				
31				
32				
33				
34				
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39				

A waiver form will be required for employees and their dependents who are waiving any of the coverages available under your plan.

- I hereby certify that I have read this document and that the information provided is accurate and complete.
- I certify that all employees actively working for me are compensated in a manner that complies with all applicable federal and state minimum wage requirements.
- I certify that the information provided can be substantiated by business documents. Upon request, I agree to provide the documentation requested to establish eligibility and that participation requirements are met at all times coverage is provided by Humana (i.e. Wage and Tax form, Taxpayer I.D. numbers, W-2 forms, etc.)
- I understand that providing incomplete, inaccurate or untimely information may void, reduce or terminate any individual or group coverage or result in an increase in premium.

Signature of Employer \_\_\_\_\_ Date \_\_\_\_\_  
 (Owner, Officer, Partner)

Print name of Employer \_\_\_\_\_ Title \_\_\_\_\_

# Eligibility Reference Guide

This generic reference guide should help in determining that a bonafide business exists and helps establish that there is a legitimate employer/employee relationship for each fulltime employee. **This guide does not include state specific variations.**

Notes:

- An Eligibility Certification Form should be used for ANY employee whose name does not appear on a Quarterly Wage and Tax Report;
- To be considered eligible for coverage, the individual must meet the definition of a full-time employee;
- Authoritative documentation should be provided on any group that cannot produce a Wage & Tax Report. The letter should be from the employer explaining why the Wage & Tax is not available.
- Copies of alternative documentation must be provided to Underwriting for approval.

**Please note that this document is not all-inclusive. Humana reserves the right to request any additional information as deemed appropriate.**

BUSINESS TYPE	IN BUSINESS (MORE THAN 3 MONTHS)
<p><b>Sole Proprietorship</b></p> <p>A Sole Proprietor will not appear on Form 941, however other employees should appear</p>	<p>Quarterly Wage and Tax Report</p> <p>For the Sole Proprietor not on W&amp;T: Eligibility Certification Form ; Schedule C (Profit and Loss) <b>OR</b> Schedule SE( Self–employment tax) both of which are filed with Form 1040 (Income Tax Return)</p>
<p><b>Partnerships</b></p> <p>General partners will not have Form 941 or W2.</p>	<p>Quarterly Wage and Tax Report</p> <p>For the Partners not on W&amp;T: Eligibility Certification Form; Schedule K-1 1065 (Partners Share of Income) or K-1 1120S (Shareholder’s Share of Income)</p>
<p><b>“C” Corp</b></p>	<p>Quarterly Wage and Tax Report</p> <p>For the Owners not on W&amp;T: Eligibility Certification Form; Form 1120 <b>AND</b> Schedule E (illustrating officer’s compensation)</p>
<p><b>“S” Corp</b></p>	<p>Quarterly Wage and Tax Report</p> <p>For the Owners not on W&amp;T: Eligibility Certification Form; Form 1120S <b>AND</b> Schedule K1 (illustrating shareholder’s income)</p>
<p><b>LLC (Limited Liability Company)</b></p>	<p>Quarterly Wage and Tax Report</p> <p>For the Owners not on W&amp;T: Eligibility Certification Form; LLC may file as a “C” Corporation, <b>OR</b> Partnership Determine which applies and follow the corresponding requirements.</p>

<b>Farms</b>	<p>Quarterly Wage and Tax Report</p> <p>Depending on the structure of the group, farms may file the following forms.  1040 (schedule F, K1, SE)  1065  1065B</p>
<b>Non-Profit Organizations</b>	<p>Quarterly Wage and Tax Report  Form 940/941</p> <p>There are many forms that non-profit groups may file. Ask the group what they actually file with the government</p>
<b>Independent Contractors</b>	<p>Quarterly Wage and Tax Report  Full-time Employment Questionnaire</p> <p>For those independent contractors not on W&amp;T:  Form 1099:  Eligibility Certification Form</p>
<b>Groups Utilizing Payroll Services/Administrative Services Only</b>	<p>Quarterly Wage and Tax Report</p>

**Groups in business less than (6) months:**

Are not eligible unless a state prohibits us from administering this provision.

- Exceptions will be reviewed on a case-by-case basis.
- Documentation should be carefully evaluated for groups in business less than (6) months where we are mandated to entertain.

# Employer Group Application

**TEXAS**  
 HUMANA / HUMANADENTAL / COMPBENEFITS

**You have the option to choose this Consumer Choice of Benefits Health Insurance Plan that, either in whole or in part, does not provide state-mandated health benefits normally required in accident and sickness insurance policies in Texas. This standard health benefit plan may provide a more affordable health insurance policy for you although, at the same time, it may provide you with fewer health benefits than those normally included as state-mandated health benefits in policies in Texas. If you choose this standard health benefit plan, please consult with your insurance agent to discover which state-mandated health benefits are excluded in this policy.**

Please refer to your proposal to complete this application. This document will form part of any contract issued. Print clearly in black ink, and answer all questions or indicate "not applicable".

**Your Business Profile**

Business name		Federal tax ID number	
Location address (not a P.O. Box)			
City	State	Zip code	County
Do you have more than one location? <input type="radio"/> No <input type="radio"/> Yes			
Billing address (if different)			
City	State	Zip code	County
Nature of business or SIC number		Date company established	
Business status: <input type="radio"/> Corporation <input type="radio"/> Partnership <input type="radio"/> Sole Proprietorship <input type="radio"/> Other: (explain)			
Business phone number		Fax number	
Management contact		Administrative contact	
Management contact e-mail address			
Management contact: Mother's maiden name _____ <i>This will be used to gain access to the Employer Self-Service Center on www.Humana.com.</i>			

All Certificate(s) of Insurance/Evidence(s) of coverage are available to you and your employees on our Web site, www.humana.com. If you would also like to receive a paper copy of this information, you must fill in the circle below.

I wish to receive paper copies of Certificate(s) of Insurance/Evidence(s) of Coverage.

**General Eligibility**

Requested effective date	How many employees are on your payroll?
How many hours per week must your employees usually work to be eligible? (select between 20 and 30 hours)	
For groups of 51-99: Do you want to exclude a class of employees? <input type="radio"/> No <input type="radio"/> Yes	
If yes, check class to exclude: (Options may not be available for all plans. Refer to the Underwriting Requirements for each plan.)	
<input type="radio"/> union <input type="radio"/> non union <input type="radio"/> hourly <input type="radio"/> salary <input type="radio"/> management <input type="radio"/> non-management	
How long must employees wait after hire date to become eligible? <input type="radio"/> 0 days <input type="radio"/> 30 days <input type="radio"/> 60 days	
<input type="radio"/> 90 days (groups of 2-50 may not exceed 90 days) <input type="radio"/> Other, specify:	
How many employees are eligible for coverage?	
New employee effective date provision: <input type="radio"/> First of month following waiting period (required for HMO, POS and DHMO plans)	
<input type="radio"/> Immediately following waiting period	
On all plans, the employee termination date coincides with the effective date provision.	
When offering multiple choice plans, the waiting period and effective date must be the same on all plans.	
Is this employer required to comply with COBRA regulation? <input type="radio"/> No <input type="radio"/> Yes	
Are any present or former employees/dependents currently on or eligible to elect COBRA/State Continuation? <input type="radio"/> No <input type="radio"/> Yes	
If yes, enter information below. Attach a separate sheet if necessary.	

Name of applicant	Qualifying event (e.g., termination of employment, divorce, etc.)	Date of qualifying event	Date COBRA or State Continuation coverage terminates

## Employer Agreement

You the employer, understand, agree and represent:

- You have read this document and the information you provided is accurate and complete to the best of your knowledge and can be substantiated by your business records.
- You have received and reviewed a proposal and the applicable regulatory information required by your state.
- Neither you nor the agent/broker/producer 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.
- The first month's estimated premium (which may include a monthly administrative fee), and fully completed enrollment information for all eligible persons requesting insurance coverage must be submitted with this application before action is taken on this application.
- For small employers, you may be charged a monthly administrative fee which will not be more than \$5.00 per person based on coverage selected. For large employers, you may be charged a monthly administrative fee.
- You will collect any employee contribution toward premium. Our acceptance of premium does not guarantee coverage.
- You will provide the documentation requested by us which establishes that all eligibility, underwriting, and participation requirements of the plan or group contract are met.
- Only individuals who meet the eligibility requirements of the plan are eligible to maintain coverage.
- For medical coverage, you understand that providing fraudulent information or intentional misrepresentation of a material fact including providing incomplete, inaccurate information may void, reduce, or terminate an individual's coverage or the group's coverage. (Health related factors will not be used to void or terminate an individual's medical coverage or a small employer group's coverage.)
- If choosing the HDHP Indexing plan, deductible and out of pocket amounts are established by IRS guidelines. Adjustments to these amounts by the IRS will be made to the policy, without notice, upon renewal of the group.
- The agent/broker/producer has explained to me that Humana has made available to my firm the State Medical Plans prescribed by Texas House Bill 1212, providing that my firm, as defined in the Act, is a small employer of 2-50 eligible employees (this paragraph not applicable to large employers).

This document will form part of any contract issued. Coverage is not in effect unless and until you receive written notification from us.

For large employers, if this application is declined, we will return the premium deposit submitted with this application.

**Do not cancel any current group coverage until you receive written notice from us that we have issued coverage.**

Dated on: \_\_\_\_\_  
(month, date, year)

By: \_\_\_\_\_  
(employer signature)

Dated at: \_\_\_\_\_  
(city and state)

By: \_\_\_\_\_  
(title)

## Agent/Producer Information

<p><b>1. Agent/Agency of Record (for commissions and correspondence):</b></p> <p>Name (print)</p> <hr/> <p>Tax ID / Social Security Number / Humana Agent Number</p> <hr/> <p>Commission split: <input type="radio"/> No <input type="radio"/> Yes If yes, percentage: (total should equal 100%)</p> <hr/> <p><b>1. Writing Agent/Producer:</b></p> <p>Name (print)</p> <hr/> <p>Social Security Number</p> <hr/> <p>Commission split: <input type="radio"/> No <input type="radio"/> Yes If yes, percentage: (total should equal 100%)</p>	<p><b>2. Agent/Agency of Record (for split-commissions):</b></p> <p>Name (print)</p> <hr/> <p>Tax ID / Social Security Number / Humana Agent Number</p> <hr/> <p>Percentage of sales: <input type="radio"/> No <input type="radio"/> Yes If yes, percentage: (total should equal 100%)</p> <hr/> <p><b>2. Writing Agent/Producer:</b></p> <p>Name (print)</p> <hr/> <p>Social Security Number</p> <hr/> <p>Percentage of sales: <input type="radio"/> No <input type="radio"/> Yes If yes, percentage: (total should equal 100%)</p>
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## General Agency

General agency information pertains to  Agent/Agency of Record #1  Agent/Agency of Record #2

Name (print) \_\_\_\_\_ Tax ID / Humana Agent Number \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

As the Writing Agent/Broker/Producer, I acknowledge that I am responsible to meet with the employer submitting this application in order to fully and accurately represent the terms and conditions of the plans and services of the offering or insuring entity, including an explanation of the State Medical Plans to employers of 2-50 eligible employees. These provisions are available to me and the employer in the Regulatory Pre-enrollment Disclosure or other plan literature.

Writing Agent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### **The following applies to all companies and products**

The companies listed on this Employer Group Application, severally or collectively as the context may require, are referred to in this application as we, us and our.

You, the participating employer, policyholder, contractholder, or group plan sponsor, intend to establish, sponsor, and endorse an employee benefit plan which will be governed by Employee Retirement Income Security Act of 1974 (ERISA). You are the ERISA plan administrator.

You agree to make available your records which we determine are relevant to this application and group coverage for inspection by the Trustee, Administrator, us or our representative during your normal business hours.

As claims administrator, we shall, in accordance with state and federal law, 1) interpret Policy, Group Plan, or Group Contract provisions, 2) make decisions regarding eligibility for coverage and benefits, and 3) resolve factual questions relating to coverage and benefits.

You understand and agree that failure to remit and pay premium when due will be considered a default in premium payment, and that coverage will be terminated by us, following a grace period of 31 days from the date of non-payment of premium.

We may terminate your coverage according to the termination section of the Policy, Group Plan or Group Contract. If coverage is terminated by us for non-payment of premium, you will still owe and we will collect all due premium including premium for the grace period.

### **The following applies to medical plans only**

Small employer means a person, firm, corporation, partnership or association actively engaged in business, which employed an average of at least two but not more than 50 employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year, unless

You understand and agree that your coverage is renewed on a monthly basis 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, after your insurance has been in effect under the Policy for six consecutive months. You will receive advance written notice.

For you to remain eligible for the Policy, Group Plan or Group Contract, the eligibility, underwriting and participation requirements must be maintained, for each respective coverage. Failure to maintain the plan eligibility and underwriting requirements will terminate your coverage under the policy. If you fail to meet the participation requirements for 6 consecutive months, your coverage will be terminated on the first renewal date following the end of this 6-month period. Other termination provisions are stated in the Policy, Group Plan or Group Contract.

Based upon our standard underwriting practice, we may require an employee or dependent to submit Evidence of Health Status. We have the right to use the information provided by you and any applicant (employee or dependent) to determine whether coverage will be provided, to determine eligibility and to establish appropriate premiums. Any health related information that has been provided will not be used to decline medical coverage of an individual or medical coverage of a small employer.

otherwise provided under the state law. Entities that are affiliated companies or that are eligible to file a combined tax return for the purpose of taxation, are considered one employer.

**HUMANA**<sup>®</sup>  
*Guidance* when you need it most

PPO and Classic Medical plans, Life, Vision and Short-Term Income Protection plans insured or administered by Humana Insurance Company. HMO plans offered by Humana Health Plan of Texas, Inc., a Health Maintenance Organization. POS plans offered by Humana Health Plan of Texas, Inc., a Health Maintenance Organization and insured or administered by Humana Insurance Company.

**HUMANA**<sup>®</sup>  
*Specialty Benefits*

Prepaid and AdvantagePlus dental benefits offered and administered by DentiCare, Inc. (d/b/a CompBenefits). All other Dental plans insured or administered by HumanaDental Insurance Company or Humana Insurance Company. CompBenefits Vision plan insured and administered by CompBenefits Insurance Company.

# Humana Small Group Medical

Humana Insurance Company  
Humana Health Plan of Texas, Inc.

HMO Premium Billing Address  
12296 Collections Center Drive  
Chicago, IL 60693

**Plan Selection (To complete this information, refer to your proposal.)**

	Plan 1	Plan 2	Plan 3
<b>Plan name</b> (as shown on your proposal)			
<b>Office visit copayment</b> (if applicable)	\$	\$	\$
<b>Coinsurance</b> (if applicable)	Participating (In) : % _____ Non-participating (Out): % _____	Participating (In) : % _____ Non-participating (Out): % _____	Participating (In) : % _____ Non-participating (Out): % _____
<b>Deductible</b> (if applicable)	Participating (In): \$ _____ Non-participating (Out): \$ _____	Participating (In): \$ _____ Non-participating (Out): \$ _____	Participating (In): \$ _____ Non-participating (Out): \$ _____
<b>Out-of-pocket limit</b> (if applicable)	Participating: \$ _____ Non-participating: \$ _____	Participating: \$ _____ Non-participating: \$ _____	Participating: \$ _____ Non-participating: \$ _____
<b>Network name</b> (if applicable)			

**Plan Riders (Please refer to your proposal for rider availability with plan selected.)**

	Plan 1	Plan 2	Plan 3
<b>Deductible Carryover Credit</b>	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
<b>Supplemental Accident</b>	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
<b>Prescription Drug/Retail Card</b> (Level 1 / 2 / 3 / 4)	\$ ____ / \$ ____ / \$ ____ / ____ %	\$ ____ / \$ ____ / \$ ____ / ____ %	\$ ____ / \$ ____ / \$ ____ / ____ %
<b>Prescription Drug/Retail Card</b> (Group A / B / C / D)	\$ ____ a / \$ ____ a / \$ ____ a / \$ ____ a	\$ ____ a / \$ ____ a / \$ ____ a / \$ ____ a	\$ ____ a / \$ ____ a / \$ ____ a / \$ ____ a
<b>Other:</b>	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
<b>Special State Options</b> (not available with Consumer Choice Plans)		<b>PPO and Classic Products</b>	<b>HMO and POS Products</b>
<b>Invitro Fertilization Benefit</b>	<input type="radio"/> No <input type="radio"/> Yes	Optional	Optional
<b>Serious Mental Illness Benefit</b>	<input type="radio"/> No <input type="radio"/> Yes	Optional	Included
If your group is a municipality, county, school district or other political subdivision of the state, this benefit must be provided.			
<b>Speech and Hearing Rider</b>	<input type="radio"/> No <input type="radio"/> Yes	Included	Optional

**Consumer Choice Medical Plans**

You have the option to choose the Consumer Choice PPO Benefits Health Plan, Consumer Choice HMO Benefits Health Plan, or the Consumer Choice POS Benefits Health Plan that either in whole or in part, does not provide state-mandated health benefits normally required in Texas health benefit plans. A consumer choice standard health benefit plan may provide more affordable health benefits for you and your employees although, at the same time, it may provide you and your employees fewer health benefits than those normally included as state-mandated health benefits in Texas health benefit plans. If you choose a consumer choice standard benefit plan, please consult with your insurance agent to discover which state-mandated health benefits are reduced and/or excluded.

**Consumer Choice PPO:**  No  Yes

**Consumer Choice HMO:**  No  Yes

**Consumer Choice POS:**  No  Yes

**Plan Selection (continued)**

**Below is the Required Disclosure Notice for Group PPO & HMO Consumer Choice Benefit Plans Issued in Texas. To obtain a copy of the required Consumer Choice Disclosure Notice for Consumer Choice POS Benefit Plans Issued in Texas, please consult your insurance agent.**

I acknowledge the Consumer Choice PPO Benefits Health Plan, Consumer Choice HMO Benefits Health Plan, or the Consumer Choice POS Benefits Health Plan that either in whole or in part, does not provide state-mandated health benefits normally required in Texas health benefit plans. I am aware a consumer choice standard benefit health plan may provide more affordable health benefits although, at the same time, it may provide fewer health benefits than those normally included as state-mandated health benefits in Texas health benefit plans.

**Excluded PPO State Mandates**

Chemical & Alcohol Dependency  
TMJ  
Home Health Care  
Serious Mental Illness  
Invitro  
Speech & Hearing

**Excluded HMO State Mandates**

Chemical & Alcohol Dependency  
Oral Contraceptive Drugs & Devices  
TMJ  
Serious Mental Illness  
Invitro

The Consumer Choice Health Benefit Plans may include requirements and/or restrictions on deductibles, coinsurance, copayments, or annual or lifetime maximum benefit amounts that differ from other PPO & HMO plans. I understand that I may obtain from the Department of Insurance a consumer brochure with more information on Consumer Choice Health Benefit Plans, either by visiting the TDI website at [www.tdi.state.tx.us/consumer/indexc.html](http://www.tdi.state.tx.us/consumer/indexc.html), or by calling 1-800-252-3439.

**(Only sign and complete this section if a Consumer Choice Plan was selected.)**

I acknowledge that I was offered the opportunity to apply for an accident and sickness insurance policy or evidence of coverage in the same category that most closely approximates the consumer choice health benefit plan offered.

Group Representative Signature: \_\_\_\_\_

Title: \_\_\_\_\_ Date Signed: \_\_\_\_\_

**Underwriting Requirements**

- You may not sponsor a medical plan from a carrier other than Humana.
- Medical coverage is available to employers with two or more enrolled employees.
- If the only employees of a two-life group are husband and wife, each must enroll separately as an employee and maintain eligibility. The group is only eligible if a bona fide business entity exists.
- Minimum employer contribution toward employee premium is 50%.

- Retirees of a small employer are not eligible for retiree coverage.
- There are no excluded class options for small group medical coverage.
- If you do not maintain eligibility, underwriting, and participation requirements, we will terminate your coverage.

**Participation**

- All plans – 75%

**Group Information**

How much will you contribute to premium? Employee \_\_\_\_\_% Dependent \_\_\_\_\_%

Are there any other entities associated with this company that are eligible to file a combined tax return?  No  Yes  
If yes, enter information below.

Company Name	Total Employees

Will your employees have access to another carrier's medical coverage by virtue of their employment with you?  No  Yes  
If yes, name of carrier: \_\_\_\_\_

Did you have prior group medical coverage?  No  Yes If yes, submit most recent carrier billing with effective and termination dates. \_\_\_\_\_

How many medical carriers have you had in the past five years? \_\_\_\_\_

Is the agent/broker/producer representing you for this application your current agent/broker/producer of record?  No  Yes \_\_\_\_\_

**Group Information (continued)**

Provide the current and renewal medical insurance premium rates below and attach a copy of your most recent premium bill.

Date of renewal:

<p><b>Current Plan 1 current carrier rates:</b></p> <p>Employee: \$ _____ Spouse: \$ _____                  Child(ren): \$ _____ Family: \$ _____</p> <p>Plan design: _____</p> <p>Office visit copay: _____</p> <p>Per confinement copay: _____</p> <p>Deductible:      • Participating _____                                           • Non-participating _____</p> <p>Out-of-pocket:    • Participating _____                                           • Non-participating _____</p> <p>Coinsurance stoploss: • Participating _____                                                   • Non-participating _____</p> <p>Emergency room copay: _____</p> <p>Prescription drug benefit: _____</p> <p>Do you as the employer currently fund any of the plan deductible for the employees?    <input type="radio"/> No    <input type="radio"/> Yes                  If yes, how much of the deductible do you fund? _____</p> <p><b>Renewal rates:</b> In the parentheses, please indicate the number of employees enrolled in each tier, if available.</p> <p>Employee (    ): \$ _____ Spouse (    ): \$ _____                  Child(ren) (    ): \$ _____ Family (    ): \$ _____</p>	<p><b>Current Plan 2 current carrier rates:</b></p> <p>Employee: \$ _____ Spouse: \$ _____                  Child(ren): \$ _____ Family: \$ _____</p> <p>Plan design: _____</p> <p>Office visit copay: _____</p> <p>Per confinement copay: _____</p> <p>Deductible:      • Participating _____                                           • Non-participating _____</p> <p>Out-of-pocket:    • Participating _____                                           • Non-participating _____</p> <p>Coinsurance stoploss: • Participating _____                                                   • Non-participating _____</p> <p>Emergency room copay: _____</p> <p>Prescription drug benefit: _____</p> <p>Do you as the employer currently fund any of the plan deductible for the employees?    <input type="radio"/> No    <input type="radio"/> Yes                  If yes, how much of the deductible do you fund? _____</p> <p><b>Renewal rates:</b> In the parentheses, please indicate the number of employees enrolled in each tier, if available.</p> <p>Employee (    ): \$ _____ Spouse (    ): \$ _____                  Child(ren) (    ): \$ _____ Family (    ): \$ _____</p>
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1. Has any employee been unable to work 10 or more consecutive days in the past 12 months due to an illness or injury?     No     Yes
2. Is any employee presently not performing his or her duties on a full-time basis due to an illness or injury?     No     Yes
3. To the best of your knowledge, is there any employee, individual in a retiree class, dependent (spouse or child), COBRA beneficiary, or individual within their COBRA/State Continuation election period:
  - confined at home, in a hospital, or in a treatment facility;
  - who incurred more than \$10,000 of medical expenses in the past 24 months;
  - who has been advised within the last 90 days to have surgery or be hospitalized; who received treatment, had treatment recommended, or had medication prescribed by a doctor, psychiatrist, psychologist or other licensed practitioner within the past 24 months for any of the following: (check all that apply)
    - AIDS or an AIDS-related complex or other immune system disorder
    - Alcohol or drug abuse or dependence, or psychological disorder
    - Cancer or cancerous tumor
    - Heart or vascular disease or stroke
    - Diabetes or any disease or disorder of the kidneys, liver or lungs
    - Systemic disease including, but not limited to Lupus, Multiple Sclerosis, or Muscular Dystrophy
    - Organ transplant (other than corneal)

If you answered yes to questions 1-3 above, please indicate the question number and explanation.

Question #	Member Status*	Age	Medical Condition/Diagnosis	Date(s) of Treatment	Medication Name/Dosage	Past/Current/Future Treatment

\* Member Status: E=Employee D=Dependent C=COBRA/State Continuation R=Retiree

Has your company, at any time during the past 24 months, had medical coverage terminated or a renewal of medical coverage refused?

No     Yes    If yes, please explain:

Have any medical benefits now, or within the past 24 months, been funded by you in any manner other than health insurance premium payment?     No     Yes    If yes, please provide details and attach medical claims experience for the applicable time period up to 24 months.

**Retiree Information**

Are you offering coverage to retirees?     No     Yes    If yes, required age: \_\_\_\_\_ Minimum years of service: \_\_\_\_\_

Please refer to your proposal to complete this application. This document will form part of any contract issued. Print clearly in black ink, and answer all questions or indicate "not applicable".

**Plan Selection**

Is this a SmartSuite selection?  No  Yes

	Plan 1	Plan 2
Plan Name (as shown on your proposal)		
Coinsurance:	Participating (In) : % ____/____/____ Non-participating (Out): % ____/____/____	Participating (In) : % ____/____/____ Non-participating (Out): % ____/____/____
Deductible:	\$	\$
Annual Maximum:	\$	\$
Preventive Services Deductible Options:	<input type="radio"/> Apply Deductible <input type="radio"/> Waive Deductible	<input type="radio"/> Apply Deductible <input type="radio"/> Waive Deductible
Periodontic/Endodontic Options:	<input type="radio"/> Basic <input type="radio"/> Major	<input type="radio"/> Basic <input type="radio"/> Major
Orthodontia Options:	<input type="radio"/> Child Only: Lifetime Orthodontia Maximum \$ _____ <input type="radio"/> Adult And Child: Lifetime Orthodontia Maximum \$ _____	
Composite Fillings for Molars:	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
Implant Coverage:	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
Out of network reimbursement options:	<input type="radio"/> Maximum allowable fee <input type="radio"/> In-network fee schedule	<input type="radio"/> Maximum allowable fee <input type="radio"/> In-network fee schedule
Open Enrollment:	<input type="radio"/> No <input type="radio"/> Yes	

**Underwriting Requirements**

- Underwriting approval is required to offer more than one dental carrier to your employees.
- Dental coverage is available to employers with two or more enrolled employees.
- If the only employees of a two-life group are husband and wife, each must enroll separately as an employee and maintain eligibility. The group is only eligible if a bona fide business entity exists.
- Minimum employer contribution toward employee premium is 25%. This minimum does not apply to Voluntary coverage.
- Retiree coverage is available to employers with 51 or more enrolled employees.
- Minimum age for retiree coverage is 50.
- Excluded class options: hourly, salary, union, non-union, management, non-management.
- If you do not maintain eligibility, underwriting, and participation requirements, we will terminate your coverage.

**Participation requirements:**

Eligible Employees	Participation
2+ (Employer Pays 100% of Premium)	100%
2+ (Employees Contribute to Premium)	75%
2+ Eligible Employees with Spousal Waiver	50%

**Voluntary Participation Requirements:**

Eligible Employees	Participation
<b>Traditional Preferred, PPO, Preventive Plus</b>	
2+ Employees	Two enrolled employees or 25% whichever is greater.
<b>Advantage Plus</b>	
10+ Employees	Ten enrolled employees or 25% whichever is greater
<b>Prepaid</b>	
2+ Employees	Two or more enrolled employees
<b>Prepaid with orthodontia coverage</b>	
10+ employees	Ten or more employees

**Group Information**

How much will you contribute to premium? Employee \_\_\_\_\_% Dependent \_\_\_\_\_%

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Are you offering dental coverage to retirees?  No  Yes If yes, required age: \_\_\_\_\_ Minimum years of service: \_\_\_\_\_

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Did you have prior group dental coverage?  No  Yes  
If yes, submit most recent carrier billing with effective and termination dates.

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Did your prior dental coverage include orthodontia?  No  Yes

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Will your employees have access to another carrier's dental coverage by virtue of their employment with you?  No  Yes  
If yes, name of carrier: \_\_\_\_\_

Please refer to your proposal to complete this application. This document will form part of any contract issued. Print clearly in black ink, and answer all questions or indicate "not applicable."

**Plan Selection**

**Basic Employee Life and Accidental Death and Dismemberment**

- Flat Amount—indicate level: \$ \_\_\_\_\_
- Salary Plan—options are 1x to 7x salary, rounded to the next highest \$1,000. Indicate salary level: \_\_\_\_\_ x Salary
- Position Schedule—classifications cannot exceed 2.5 times between each class and 10 times between the lowest and highest class.

Class	Description	Benefit Amount/ Salary Factor
I	_____	_____
II	_____	_____
III	_____	_____
IV	_____	_____

**Basic Dependent Life:**  No  Yes  
Available only to employees enrolled for Basic Life.

**Voluntary Employee Life:**  No  Yes  
If yes: AD&D  No  Yes

**Voluntary Dependent Life:**  No  Yes  
Available only to employees enrolled for Voluntary Life.

**Portability of coverage:**  
Groups 2-99: Included  
Groups 100+:  No  Yes

**Underwriting Requirements**

- Basic Life coverage is available to employers with two or more enrolled employees.
- Voluntary life coverage is available to employers with five or more enrolled employees.
- If the only employees of a two-life group are husband and wife, each must enroll separately as an employee and maintain eligibility. The group is only eligible if a bona fide business entity exists.
- Minimum employer contribution toward employee premium is 50%. This minimum does not apply to voluntary coverage.
- Retirees are not eligible for life coverage.
- Excluded class options: hourly, salary, union, non-union, management, non-management.
- If you do not maintain eligibility, underwriting, and participation requirements, we will terminate your coverage.

**Basic Term Life participation**

- Non-contributory plans—100%
- Contributory plans—75%
- Single medical carrier: You must have 100% participation of all eligible employees for this coverage, regardless of whether they have medical coverage through their spouse for non-contributory plans. For contributory plans, 75% participation required; minimum employer contribution 50%.
- Multiple medical carrier: If you offer more than one medical carrier, you must enroll 100% of those employees who take our coverage regardless of the percentage of contribution paid by you.

**Voluntary Term Life participation**

- Five employees or 25%, whichever is greater.

**Group Information**

How much will you contribute to basic life premium? Employee \_\_\_\_\_% Dependent \_\_\_\_\_%

Please refer to your proposal to complete this information. This document will form part of any contract issued.

## Plan Selection

	Plan 1	Plan 2
Plan Name (as shown on your proposal)		
Open Enrollment:	<input type="radio"/> No <input type="radio"/> Yes	

## Group Information

How much will you contribute to premium? Employee \_\_\_\_\_% Dependent \_\_\_\_\_%

Are you offering vision coverage to retirees?  No  Yes If yes, required age: \_\_\_\_\_ Minimum years of service: \_\_\_\_\_

Will your employees have access to another carrier's vision coverage by virtue of their employment with you?  No  Yes  
If yes, name of carrier: \_\_\_\_\_

Thank you for choosing Humana.

# Notice of Privacy Practices

for your **personal** health and financial information

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

**The privacy of your personal and health information is important. You don't need to do anything unless you have a request or complaint.**

Relationships are built on trust. One of the most important elements of trust is respect for an individual's privacy. We at Humana value our relationship with you, and we take your personal privacy seriously.

This notice explains Humana's privacy practices, our legal responsibilities, and your rights concerning your personal and health information. We follow the privacy practices described in this notice and will notify you of any changes.

We reserve the right to change our privacy practices and the terms of this notice at any time, as allowed by law. This includes the right to make changes in our privacy practices and the revised terms of our notice effective for all personal and health information we maintain. This includes information we created or received before we made the changes. When we make a significant change in our privacy practices, we will change this notice and send the notice to our health plan subscribers.

## What is personal and health information?

Personal and health information - from now on referred to as "information" - includes both medical information and individually identifiable information, like your name, address, telephone number, or Social Security number. The term "information" in this notice includes any personal and health information created or received by a healthcare provider or health plan that relates to your physical or mental health or condition, providing healthcare to you, or the payment for such healthcare. We protect this information in all formats including electronic, written and oral information.

## How does Humana protect my information?

In keeping with federal and state laws and our own policy, Humana has a responsibility to protect the privacy of your information. We have safeguards in place to protect your information in various ways including:



- Limiting who may see your information
- Limiting how we use or disclose your information
- Informing you of our legal duties about your information
- Training our associates about company privacy policies and procedures

## How does Humana use and disclose my information?

We must use and disclose your information:

- To you or someone who has the legal right to act on your behalf
- To the Secretary of the Department of Health and Human Services
- Where required by law.

We have the right to use and disclose your information:

- To a doctor, a hospital, or other healthcare provider so you can receive medical care
- For payment activities, including claims payment for covered services provided to you by healthcare providers and for health plan premium payments
- For healthcare operation activities including processing your enrollment, responding to your inquiries and requests for services, coordinating your care, resolving disputes, conducting medical management, improving quality, reviewing the competence of healthcare professionals, and determining premiums
- For performing underwriting activities. However, we will not use any results of genetic testing.
- To your plan sponsor to permit them to perform plan administration functions such as eligibility, enrollment and disenrollment activities. We may share summary level health information about you with your plan sponsor in certain situations such as to allow your plan sponsor to obtain bids from other health plans. We will not share detailed health information to your plan sponsor unless you provide us your permission or your plan sponsor has certified they agree to maintain the privacy of your information.

# Notice of Privacy Practices *(continued)*

- To contact you with information about health-related benefits and services, appointment reminders, or about treatment alternatives that may be of interest to you
- To your family and friends if you are unavailable to communicate, such as in an emergency
- To your family and friends or any other person you identify, provided the information is directly relevant to their involvement with your health care or payment for that care. For example, if a family member or a caregiver calls us with prior knowledge of a claim, we may confirm whether or not the claim has been received and paid.
- To provide payment information to the subscriber for Internal Revenue Service substantiation
- To public health agencies if we believe there is a serious health or safety threat
- To appropriate authorities when there are issues about abuse, neglect, or domestic violence
- In response to a court or administrative order, subpoena, discovery request, or other lawful process
- For law enforcement purposes, to military authorities and as otherwise required by law
- To assist in disaster relief efforts
- For compliance programs and health oversight activities
- To fulfill Humana's obligations under any workers' compensation law or contract
- To avert a serious and imminent threat to your health or safety or the health or safety of others
- For research purposes in limited circumstances
- For procurement, banking, or transplantation of organs, eyes, or tissue
- To a coroner, medical examiner, or funeral director.

## **Will Humana use my information for purposes not described in this notice?**

In all situations other than described in this notice, Humana will request your written permission before using or disclosing your information. You may revoke your permission at any time by notifying us in writing. We will not use or disclose your information for any reason not described in this notice without your permission.

## **What does Humana do with my information when I am no longer a Humana member or I do not obtain coverage through Humana?**

Your information may continue to be used for purposes described in this notice when your membership is terminated or you do not obtain coverage through

Humana. After the required legal retention period, we destroy the information following strict procedures to maintain the confidentiality.

## **What are my rights concerning my information?**

The following are your rights with respect to your information:

- **Access** – You have the right to review and obtain a copy of your information that may be used to make decisions about you, such as claims and case or medical management records. You also may receive a summary of this health information. If you request copies, we may charge you a fee for each page, a per hour charge for staff time to locate and copy your information, and postage.
- **Adverse Underwriting Decision** – You have the right to be provided a reason for denial or adverse underwriting decision if Humana declines your application for insurance.\*
- **Alternate Communications** – You have the right to receive confidential communications of information in a different manner or at a different place to avoid a life threatening situation. We will accommodate your request if it is reasonable.
- **Amendment** – You have the right to request an amendment of information we maintain about you if you believe the information is wrong or incomplete. We may deny your request if we did not create the information, we do not maintain the information, or the information is correct and complete. If we deny your request, we will give you a written explanation of the denial.
- **Disclosure** – You have the right to receive a listing of instances in which we or our business associates have disclosed your information for purposes other than treatment, payment, health plan operations, and certain other activities. Effective April 1, 2003 or whenever you became a Humana member, Humana began maintaining these types of disclosures and will maintain this information for a period of six years. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.
- **Notice** – You have the right to receive a written copy of this notice any time you request.
- **Restriction** – You have the right to ask to restrict uses or disclosures of your information. We are not required to agree to these restrictions, but if we do, we will abide by our agreement. You also have the

\* This right applies only to our Massachusetts residents in accordance with state regulations.

# Notice of Privacy Practices *(continued)*

right to agree to or terminate a previously submitted restriction.

## **How do I exercise my rights or obtain a copy of this notice?**

All of your privacy rights can be exercised by obtaining the applicable privacy rights request forms. You may obtain any of the forms by:

- Contacting us at 1-866-861-2762 at any time
- Accessing our Website at **Humana.com** and going to the Privacy Practices link
- E-mailing us at [privacyoffice@humana.com](mailto:privacyoffice@humana.com)

Send completed request form to:  
Humana Inc.  
Privacy Office 003/10911  
101 E. Main Street  
Louisville, KY 40202

## **What should I do if I believe my privacy has been violated?**

If you believe your privacy has been violated in any way, you may file a complaint with Humana by calling us at: 1-866-861-2762 any time.

You may also submit a written complaint to the U.S. Department of Health and Human Services, Office of Civil Rights (OCR). We will give you the appropriate OCR regional address on request. You also have the option to e-mail your complaint to [OCRComplaint@hhs.gov](mailto:OCRComplaint@hhs.gov). We support your right to protect the privacy of your personal and health information. We will not retaliate in any way if you elect to file a complaint with us or with the U.S. Department of Health and Human Services.

## **PRIVACY NOTICE CONCERNING FINANCIAL INFORMATION**

Humana and our affiliates understand that the privacy of your personal information is important to you. We take your privacy seriously and your trust in our ability to protect your private information is very important to us. This notice describes our policy regarding the confidentiality and disclosure of personal financial information.

## **How does Humana collect information about me?**

We collect information about you and your family when you complete applications and forms. We also collect information from your dealings with us, our affiliates, or others. For example, we may receive information about you from participants in the healthcare system, such as your doctor or hospital, as well as from employers or plan administrators, credit bureaus, and the Medical Information Bureau.

## **What information does Humana receive about me?**

The information we receive may include such items as your name, address, telephone number, date of birth, Social Security number, premium payment history, and your activity on our Website. This also includes information regarding your medical benefit plan, your health benefits, and health risk assessments.

## **Where will Humana disclose my information?**

We may share your information with affiliated companies and non-affiliated third parties, as permitted by law. We may also provide your information to other financial institutions with which we have joint marketing agreements in order to provide you with offers for products and services you may find of value or which are health-related.

## **What can I prevent with an opt-out disclosure?**

You can prevent the disclosures to non-affiliated third parties that provide products and services not offered by Humana or where the non-affiliated company provides services related to your plan by requesting to opt-out of such disclosures. Your opt-out request will apply to all members or individuals covered under your Humana identification number or member account.

Your opt-out request will continue to apply until you revoke your request or terminate your membership.

## **How do I request an opt-out?**

At any time you can tell Humana not to share any of your personal information with affiliated companies that provide offers of non-Humana products or services. If you wish to exercise your opt-out option, or to revoke a previous opt out request, you need to provide the following information to process your request: your name, date of birth, and your Humana member identification

# Notice of Privacy Practices *(continued)*

number. You can use any of the methods below to request or revoke your opt-out:

- Call us at 1-866-861-2762
- E-mail us at [privacyoffice@humana.com](mailto:privacyoffice@humana.com).
- Send your opt-out request to us in writing:  
Humana Inc.  
Privacy Office 003/10911  
101 E. Main Street  
Louisville, KY 40202

Humana follows all federal and state laws, rules, and regulations addressing the protection of personal and health information. In situations when federal and state laws, rules, and regulations conflict, Humana follows the law, rule, or regulation which provides greater protection.

The following affiliates and subsidiaries also adhere to Humana's privacy policies and procedures:

American Dental Plan of North Carolina, Inc.  
American Dental Providers of Arkansas, Inc.  
CarePlus Health Plans, Inc.  
Cariten Health Plan, Inc.  
Cariten Insurance Company  
CompBenefits Company  
CompBenefits Dental, Inc.  
CompBenefits Insurance Company  
CompBenefits of Alabama, Inc.  
CompBenefits of Georgia, Inc.  
CorpHealth, Inc. dba LifeSynch  
CorpHealth Provider Link, Inc.  
DentiCare, Inc.  
Emphesys, Inc.  
Emphesys Insurance Company

HumanaDental Insurance Company  
Humana AdvantageCare Plan, Inc. fna Metcare Health Plans, Inc.  
Humana Benefit Plan of Illinois, Inc. fna OSF Health Plans, Inc.  
Humana Employers Health Plan of Georgia, Inc.  
Humana Health Benefit Plan of Louisiana, Inc.  
Humana Health Insurance Company of Florida, Inc.  
Humana Health Plan of California, Inc.  
Humana Health Plan of Ohio, Inc.  
Humana Health Plan of Texas, Inc.  
Humana Health Plan, Inc.  
Humana Health Plans of Puerto Rico, Inc.  
Humana Insurance Company  
Humana Insurance Company of Kentucky  
Humana Insurance Company of New York  
Humana Insurance of Puerto Rico, Inc.  
Humana MarketPOINT, Inc.\*  
Humana MarketPOINT of Puerto Rico, Inc.\*  
Humana Medical Plan, Inc.  
Humana Medical Plan of Utah, Inc.  
Humana Pharmacy, Inc.  
Humana Wisconsin Health Organization  
Insurance Corporation  
Kanawha Insurance Company\*  
Managed Care Indemnity, Inc.  
Preferred Health Partnership, Inc.\*  
Preferred Health Partnership of Tennessee, Inc.  
The Dental Concern, Inc.  
The Dental Concern, Ltd.

\* These affiliates and subsidiaries are only covered by the Privacy Notice Concerning Financial Information section.

**HUMANA**<sup>®</sup>  
*Guidance* when you need it most

# Humana Employee Enrollment Form - 2-99 Employees

**TEXAS**

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

PPO and Classic Medical plans, Life and Vision plans insured or administered by Humana Insurance Company. HMO plans offered by Humana Health Plan of Texas, Inc., a Health Maintenance Organization. POS plans offered by Humana Health Plan of Texas, Inc., a Health Maintenance Organization and insured or administered by Humana Insurance Company. Prepaid and AdvantagePlus dental benefits offered and administered by DentiCare, Inc. (d/b/a CompBenefits). All other Dental plans insured or administered by HumanaDental Insurance Company or Humana Insurance Company. CompBenefits Vision plan insured and administered by CompBenefits Insurance Company.

Please print clearly and fill in each applicable circle.

Proposed Effective Date: \_\_/\_\_/\_\_\_\_

Company name	Company city	State
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## Enrollment Information

Relationship	Last name, First name MI	Height (ft / in)	Weight (lbs.)	Gender	Full-time student?	Date of birth	Disabled? If yes, indicate reason.
Employee		/		<input type="radio"/> F <input type="radio"/> M	N/A	__/__/____	<input type="radio"/> N Reason: <input type="radio"/> Y
Spouse		/		<input type="radio"/> F <input type="radio"/> M	N/A	__/__/____	<input type="radio"/> N Reason: <input type="radio"/> Y
Child		/		<input type="radio"/> F <input type="radio"/> M	<input type="radio"/> N <input type="radio"/> Y	__/__/____	<input type="radio"/> N Reason: <input type="radio"/> Y
Child		/		<input type="radio"/> F <input type="radio"/> M	<input type="radio"/> N <input type="radio"/> Y	__/__/____	<input type="radio"/> N Reason: <input type="radio"/> Y
Child		/		<input type="radio"/> F <input type="radio"/> M	<input type="radio"/> N <input type="radio"/> Y	__/__/____	<input type="radio"/> N Reason: <input type="radio"/> Y
Other (specify):		/		<input type="radio"/> F <input type="radio"/> M	<input type="radio"/> N <input type="radio"/> Y	__/__/____	<input type="radio"/> N Reason: <input type="radio"/> Y

<b>EMPLOYEE INFORMATION:</b>	<b>HOURS WORKED PER WEEK:</b>	<input type="radio"/> RETIREE	<b>DATE OF FULL-TIME HIRE:</b> __/__/____
SSN #	Street address		APT / Suite / Box
City	State	Zip code	Phone # ( )
Language: <input type="radio"/> English <input type="radio"/> Spanish		Email address	
Do you have a disability that affects your ability to communicate or read? <input type="radio"/> N <input type="radio"/> Y			
TX-72000-EI 5/2008			

Medical	Group #:	Benefit #:	Class/Div:	
<b>Coverage type:</b>	<input type="radio"/> Employee only <input type="radio"/> Employee and spouse <input type="radio"/> Employee and child(ren) <input type="radio"/> Family <input type="radio"/> NO COVERAGE (complete waiver)			Plan name
<b>1. Prior medical coverage during the past 18 months (individual or other group coverage)?</b> <input type="radio"/> N <input type="radio"/> Y				
Prior medical insurance carrier name	Policy #	<b>Prior coverage type:</b> <input type="radio"/> Employee only <input type="radio"/> Employee and spouse <input type="radio"/> Employee and child(ren) <input type="radio"/> Family		Effective date __/__/____ Term date __/__/____
<b>2. Other medical coverage in effect at the same time as this Humana coverage (individual or other group coverage)?</b> <input type="radio"/> N <input type="radio"/> Y				
Other Medical Insurance carrier name	Policy #	<b>Other coverage type:</b> <input type="radio"/> Employee only <input type="radio"/> Employee and spouse <input type="radio"/> Employee and child(ren) <input type="radio"/> Family		Effective date __/__/____ Term date __/__/____
<b>3. Medicare coverage:</b>				
Employee coverage: <input type="radio"/> N <input type="radio"/> Y	Medicare ID	Effective date __/__/____	Term date __/__/____	
Spouse coverage: <input type="radio"/> N <input type="radio"/> Y	Medicare ID	Effective date __/__/____	Term date __/__/____	
TX-72000-MD 5/2008				

Health Savings Account	Group #:	Benefit #:	Class/Div:	
<b>If you have medical coverage under another plan, you may not be eligible for an HSA. Please check with your tax advisor for details.</b>				
Please refer to Humana's HSA contribution worksheet to calculate your maximum allowed contribution. You can find additional information on HSAs on Humana.com. Select the Quick Link for Spending Account information on the Member page.				
Do you elect the Health Savings Account? <input type="radio"/> N <input type="radio"/> Y (If no, complete waiver.)	Beneficiary for this account will be the employee's estate. You may change beneficiary information on file with the bank that administers the HSA once the account is established.			
TX-72000-HA 5/2008				

Last name:

First name:

**Dental** Group #: Benefit #: Class/Div:

Coverage type:  Employee only  Employee and spouse  Employee and child(ren)  Family  NO COVERAGE (complete waiver) Plan name

Prior dental coverage during the past 12 months (individual or other group coverage)?  N  Y

Prior dental insurance carrier name Prior coverage type:  Employee only  Employee and spouse  Employee and child(ren)  Family Effective date: \_\_\_/\_\_\_/\_\_\_\_\_ Policy #

Prior orthodontia coverage in the past 12 months?  N  Y Term date: \_\_\_/\_\_\_/\_\_\_\_\_ Prior carrier phone # ( )

TX-72000-HD 5/2008

**Basic Life** Group #: Benefit #: Class/Div:

Primary beneficiary name (Last, First MI) Secondary beneficiary name (Last, First MI)

Class (employer will provide you with this information if needed) Annual salary (if applicable) \$ Basic dependent life?  No  Yes If no, complete waiver section.

TX-72000-BL 5/2008

**Voluntary Life** Group #: Benefit #: Class/Div:

Voluntary employee life coverage?  N  Y Amount (min \$15,000) \$ Primary beneficiary name (Last, First MI) Secondary beneficiary name (Last, First MI)

Voluntary spouse life coverage?  N  Y Amount (min. \$5,000) \$ Voluntary child(ren) life coverage?  N  Y Annual employee salary (if applicable) \$

TX-72000-VL 5/2008

**Vision** Group #: Benefit #: Class/Div:

Coverage type:  Employee only  Employee and spouse  Employee and child(ren)  Family  NO COVERAGE (complete waiver) Plan name

TX-72000-VS 5/2008

**Medical Health History**

This information should not be submitted more than 60 days prior to the effective date.

- 1. Within the past 24 months have you or any dependent to be covered had or been treated for an illness or injury, had surgery or hospitalization recommended, or are currently pregnant?  N  Y
- 2. Within the past 24 months have you or any dependent to be covered been prescribed medication?  N  Y
- 3. Have you or any dependent to be covered incurred medical expenses in excess of \$7,500 in the past 12 months?  N  Y

If you answered "yes" to any of the questions above, please provide details below and specify the question number. Attach additional signed and dated sheets if necessary.

Question # & letter	Person treated (Last name, First name)
Condition	Treatments received
Medications prescribed	Current or future treatments or medications
Date diagnosed ___/___/_____	Date last seen by a doctor ___/___/_____

Question # & letter	Person treated (Last name, First name)
Condition	Treatments received
Medications prescribed	Current or future treatments or medications
Date diagnosed ___/___/_____	Date last seen by a doctor ___/___/_____

Question # & letter	Person treated (Last name, First name)
Condition	Treatments received
Medications prescribed	Current or future treatments or medications
Date diagnosed ___/___/_____	Date last seen by a doctor ___/___/_____

TX-72000-MH 5/2008

Last name:

First name:

**Waiver (refusal of coverage)**

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.

<p><b>I hereby waive coverage for</b> (check all that apply):</p> <p>Medical for: <input type="radio"/> Myself <input type="radio"/> My spouse <input type="radio"/> My dependent child(ren)  Dental for: <input type="radio"/> Myself <input type="radio"/> My spouse <input type="radio"/> My dependent child(ren)  Basic Life for: <input type="radio"/> Myself <input type="radio"/> My spouse <input type="radio"/> My dependent child(ren)  Vision for: <input type="radio"/> Myself <input type="radio"/> My spouse <input type="radio"/> My dependent child(ren)  Health Savings Account for: <input type="radio"/> Myself</p>	<p><b>I decline to apply for group coverage because of:</b></p> <p><input type="radio"/> Spousal coverage  <input type="radio"/> Medicare supplement  <input type="radio"/> Individual coverage  <input type="radio"/> Coverage under another carrier’s plan provided by my employer  <input type="radio"/> Other:</p>
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TX-72000-WV 5/2008

**Agreement**

**True and complete acknowledgement**

I understand, agree and represent:

- I have read this document or it has been read to me and answers provided are true and complete to the best of my knowledge and belief.
- Neither my employer nor the agent can waive any question, determine coverage or insurability, alter any contract or waive any of Humana’s other rights and requirements.
- If this application for coverage is accepted, coverage will be effective on the date specified by Humana on the certificate of coverage/certificate of insurance. If I have a new dependent as a result of a qualifying event, I may in the future be able to enroll myself or my dependents provided I request enrollment within 31 days after the qualifying event.
- In the event that I should decide to apply for coverage hereafter, that subsequent application shall be subject to the applicable terms and conditions of the master group contract(s) or plan provisions which may require additional limitations and waiting periods.
- I may be required to furnish, at my own expense, evidence of health status satisfactory to Humana. This information will be used only for rating and administrative purposes and not for purposes of eligibility for coverage.
- If I am declining coverage for myself or my dependents (including my spouse) because of other coverage, I may in the future be able to enroll myself or my dependents provided that I request enrollment within 31 days after my other coverage ends.
- If any deductions are required for this coverage, I authorize those deductions from my earnings. If selecting the Health Savings Account (HSA), I authorize Humana or its banking partners to provide my account number to my employer for the purposes of depositing any contributions.
- Any intentional misrepresentation contained herein relied on by Humana may be used to reduce or deny a claim or void the contract within the contestable period if such intentional misrepresentation materially affected the acceptance of the risk.
- In the event that I should decide to apply for HMO or POS coverage hereafter, I will only be eligible at the group’s open enrollment period, unless I meet one of the exceptions of the late enrollee provisions. In the event that I should decide to apply for PPO, Classic or Indemnity coverage hereafter, Humana reserves the right to impose a 12-month pre-existing limitation.
- Any intentional material false statement, misrepresentation or omission contained herein relied on by Humana may be used to reduce or deny a claim or void the contract within the contestable period if such intentional misrepresentation or omission materially affected the acceptance of the risk.
- For small employer groups, I understand that any misstatements of health status will not be used to cancel, non-renew or void my medical coverage under this policy or plan but may result in an increase in medical premiums following a written notice as required in the Policy or Group Contract.

**Authorization**

I authorize any third party to have information regarding myself and my dependents. This includes any medical or non-medical information and to share any and all such information with Humana, its reinsurer or its legal representatives, and its affiliates.

**My dependents and I understand and agree:**

- The information obtained by use of this authorization may be used by Humana to make claims determinations, determine eligibility for coverage, eligibility for benefits under an existing policy and plan administration.
- Any information obtained will not be released by Humana to any person or organization except to reinsuring companies, the Medical Information Bureau, Inc. or other persons or organizations performing health care operations or business or legal services in connection with an application, claim or as may be otherwise lawfully required, or as I (we) may further authorize. Once personal and health (including medical, dental and pharmacy) information is disclosed pursuant to this authorization, the recipient may redisclose it and the information may not be protected by federal and state privacy requirements.
- A photographic copy of this authorization shall be as valid as the original.
- This authorization shall be valid for two years from the date shown below and I have the right to revoke this authorization at any time by writing to Humana’s Privacy Office.

**This document, together with any supplements, will form part of any contract and be the basis for any certificate of coverage/certificate of insurance issued.**

TX-72000-AA 5/2008

Last name: \_\_\_\_\_

First name: \_\_\_\_\_

**Required Disclosure Notice for PPO & HMO Consumer Choice Benefit Plans for groups with 2-50 employees**

Below is the Required Disclosure Notice for Group PPO & HMO Consumer Choice Benefit Plans Issued in Texas. To obtain a copy of the required Consumer Choice Disclosure Notice for Consumer Choice POS Benefit Plans Issued in Texas, please consult your insurance agent.

If your employer has selected the Consumer Choice PPO Benefits Health Plan, Consumer Choice HMO Benefits Health Plan or the Consumer Choice POS Benefits Health Plan, your plan in whole or in part does not provide state-mandated health benefits normally required in Texas health benefit plans.

A consumer choice standard health benefit plan may provide more affordable health benefits for you although, at the same time, it may provide you with fewer health benefits than those normally included as state-mandated health benefits in Texas health benefit plans. Please consult with your Benefit Administrator to discuss the state-mandated health benefits that are reduced and/or excluded.

**Excluded PPO State Mandates**

- Chemical & Alcohol Dependency
- TMJ
- Home Health Care
- Serious Mental Illness
- Invitro
- Speech & Hearing

**Excluded HMO State Mandates**

- Chemical & Alcohol Dependency
- Oral Contraceptive Drugs & Devices
- TMJ
- Serious Mental Illness
- Invitro

The Consumer Choice Health Benefit Plan may include requirements and/or restrictions on deductibles, coinsurance, copayments, or annual or lifetime maximum benefit amounts that differ from other PPO & HMO plans. I understand that I may obtain from the Department of Insurance a consumer brochure with more information on Consumer Choice Health Benefit Plans, either by visiting the TDI website at [www.tdi.state.tx.us/consumer/index.html](http://www.tdi.state.tx.us/consumer/index.html), or by calling 1-800-252-3439.

By signing this application, I acknowledge that I was offered the opportunity to apply for an accident and sickness insurance policy or evidence of coverage in the same category that most closely approximates the consumer choice health benefit plan offered.

TX-72000-NOTICE 5/2008

**Signature - please sign below if enrolling or waiving group coverage.**

**If you decide not to sign this authorization, Humana cannot complete your plan enrollment or determine your premium rate due to the inability to obtain the necessary information.**

Employee or legal representative signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name and relationship of legal representative: \_\_\_\_\_

TX-72000-SA 5/2008