

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.