2-50 Employer/Group Application - Texas

Humana

Humana.com

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.

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in the Small Group/Employer Application as "Humana".

PPO and Classic Medical 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. Vision plan insured and administered by Humana Insurance Company. Short Term Disability, Long Term Disability, and Workplace Voluntary Benefits plans insured or administered by Kanawha Insurance Company. Life plans insured or administered by Humana Insurance Company or Kanawha Insurance Company.

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

1. EMPLOYER COMPANY INFORMATION: Please type or print clearly in black ink

Internal use only Group number:

Full legal business name				Requested effective date _ _ / _ _ / _ _ _ _
Corporate/Situs location street address (P.O. Box not allowed)	City	State	ZIP code	County
Type of business ☐ Corporation ☐ Partnership ☐ Sole Proprietorship ☐ Church or Government entity ☐ Other (explain) _____		Date company established		Federal Tax ID
Nature of business/SIC code	Business phone number ( )		Business fax number ( )	
Do you have more than one location? ☐ No ☐ Yes				
Benefit Administrator/Management contact name:				
Phone number ( )	Fax number ( )		E-mail	
Management contact: Mother's maiden name _____ (this will be used to gain access to the Employer Self-Service Center on www.Humana.com)				
Billing contact name:				
Billing address (N/A, if same as street address)	City	State	ZIP code	
Phone number ( )	Fax number ( )	E-mail		
Are separate divisions/classes required for billing or reporting? ☐ No ☐ Yes If yes, please explain. If additional space is needed, please attach an additional page. Each additional page must be signed and dated.				

For Workplace Voluntary Benefits: Effective date of policy and due date of first premium will be (month, day, year) _ _ / _ _ / _ _ _ _

All Certificate(s) of Insurance/Evidence(s) of coverage are available to you and your employees on our Web site, www.humana.com. A paper copy of the Certificate(s) of Insurance/Evidence(s) of Coverage is available at any time to either the employer and/or the enrollee. Contact Humana to request paper copies using the number listed on member's Identification Card.

2. ELIGIBILITY REQUIREMENTS

Number of employees on payroll _____. An employee who is eligible to apply for insurance is one who usually works at least the number of hours per week as indicated in the table below.

	All	Medical	Dental	Life	Vision	STD	LTD	Group Critical Illness	Workplace Voluntary Benefits
A. Number of hours worked per week to be eligible (select between 20 and 30 hours)									
B. Number of employees in a probationary waiting period (do not include in the eligible count below in C)									
C. Total number of eligible employees									

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)

Probationary waiting period for eligible employees ☐ 0 days ☐ 30 days ☐ 60 days ☐ 90 days ☐ Other (specify)_____
If you prefer months, please select "Other" and specify the number of months.
Medical probationary waiting period must not exceed 90 days. HMO plans requiring referrals must not exceed 60 days.

Employee effective provision: (The employee termination date coincides with the effective date provision.)
☐ First of month following probationary waiting period (required for HMO, POS and DHMO plans)
☐ Immediately following probationary waiting period (required for 90 day probationary waiting period)
When offering multiple choice plans, the waiting period and effective date must be the same on all plans.
STD/LTD only (Employee termination date is last day of employment.)
Waiting period: current employees ☐ Eligible on date of employment ☐ Eligible after active employment for _____ days
Waiting period: rehired/new employees ☐ Eligible on date of employment ☐ Eligible after active employment for _____ days

Has this group been insured by Humana within the last three years? ☐ No ☐ Yes
If yes, please provide prior group number and termination date:

Is this a Collectively Bargained Plan? ☐ No ☐ Yes Name of Plan _____
Plan number _____(Assigned by Employer for use in filing IRS form 5500)

Do you wish to offer Domestic Partner coverage? ☐ No ☐ Yes

Retiree information
For groups 26+, are you offering coverage to retirees? ☐ No ☐ Yes If yes, required age _____ Minimum years of service _____

	All	Dental	Vision
Number of current retirees to be covered			

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

Short Term Disability, Long Term Disability, and Group Critical Illness only

Effective dates for changes in amounts of coverage	Effective first day of month following change	Other
Increases/decreases due to change in class	☐	
Increases/decreases requested by employee	☐	
Increases (with Evidence of Insurability) requested by employee	☐	
Decreases due to age	☐	

Short Term Disability, Long Term Disability, and Group Critical Illness only (continued)
Evidence of Insurability required if amount of coverage applied for exceeds amounts below: ☐ **Special requests:** Check box and attach signed additional sheet or letter, if custom dating, face amounts, etc. are desired.

	Class 1	Class 2		Class 1	Class 2
Employee STD	$	$	Basic group critical illness	$	$
Employee LTD	$	$	Buy-up group critical illness		

W-2 Services Option (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 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 sent to the applicant via mail. Such services will be performed in accordance with the above election and established as standard procedures.

3. COBRA/STATE CONTINUATION

Is your group subject to: COBRA ☐ No ☐ Yes State Continuation ☐ No ☐ Yes			
Number of existing COBRA participants	Medical:	Dental:	Vision:
How many in COBRA election period	Medical:	Dental:	Vision:

Are any present or former employees/dependents currently on or eligible to elect COBRA/State Continuation? ☐ No ☐ Yes
If yes, enter information below. Attach additional signed and dated sheets (reorder TX-52247), if necessary.

Name of applicant	Qualifying event (e.g. termination of employment, divorce, etc.)	Qualifying event date	COBRA/State Continuation	
			Start date	End date

4. EMPLOYER CONTRIBUTION(S)

(Medical only) Do you as an employer currently fund any of the plan deductible for the employees? ☐ No ☐ Yes
If yes, indicate amount funded $_____

(STD and LTD only) Are employer contributions taxed in employee's paycheck? ☐ No ☐ Yes

Coverage - Employer's contribution for: (Indicate $ or % amount)	Medical	Dental	Vision	Life	Voluntary Life	STD	LTD	Workplace Voluntary Benefits	Spending Account
Employee									$
Employee/spouse						N/A	N/A		$
Employee/child						N/A	N/A		$
Family						N/A	N/A		$

5. PRIOR/CURRENT CARRIER INFORMATION

	Medical	Dental	Life	Vision	STD	LTD
Is this group transferring from another group carrier?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, provide carrier name						
Proposed termination date						

Dental only: Did prior dental coverage include orthodontia? ☐ No ☐ Yes

For Workplace Voluntary Benefits - Existing coverage available to employees
Disability income carrier _____ ☐ Individual ☐ Group Coverage termination date_____
CI/Cancer carrier _____ ☐ Individual ☐ Group Coverage termination date_____

(For Medical only) Group's renewal date:

Current carrier rates	Employee $	Spouse $	Child(ren) $	Family $
Plan design		Office visit copay $	Per confinement copay $	
Coinsurance In _____% Out _____%		Deductible In _____% Out_____%	Out-of-pocket In _____% Out _____%	
Emergency room copay $		Prescription drug benefit $		
Renewal rates	Employee $	Spouse $	Child(ren) $	Family $

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

6. PRODUCT SELECTION - To complete this section, please refer to the Underwriting Requirements (reorder TX-52347). Please refer to your quote for the plan's name. Also review the Regulatory Pre-enrollment Disclosure Guide with your agent, broker, or producer.

a. MEDICAL PLANS

	Plan 1	**Plan 2**	**Plan 3**
Plan name (as shown in your proposal)			
Office/Specialist copay (if applicable)	$ / $	$ / $	$ / $
Coinsurance	In % / Out %	In % / Out %	In % / Out %
Deductible	In $ / Out $	In $ / Out $	In $ / Out $
Out-of-pocket limit	In $ / Out $	In $ / Out $	In $ / Out $
Prescription drug/Retail card (Level 1 / 2 / 3 / 4 / 5)	$ /$ /$ / %	$ /$ /$ / %	$ /$ /$ / %
Prescription drug/Retail card - RxImpact (Group A / B / C / D)	$ /$ /$ /$	$ /$ /$ /$	$ /$ /$ /$
Network name			

Additional riders: Please refer to your proposal for rider availability with plan selected.

	Plan 1	**Plan 2**	**Plan 3**
Deductible Carryover Credit	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Supplemental Accident	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Employee Assistance Program	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Other:	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Special State Options (not available with Consumer Choice Plans)		**PPO and Classic Products**	**HMO and POS Products**
In vitro Fertilization Benefit	☐ No ☐ Yes	Optional	Optional
Serious Mental Illness Benefit* (2-50 employees only)	☐ No ☐ Yes	Optional	Optional
*If your group is a municipality, county, school district or other political subdivision of the state, this benefit must be provided.			
Speech and Hearing Rider	☐ No ☐ 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

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 or Open Access HMO 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.

a. MEDICAL PLANS (continued)

Excluded PPO State Mandates	Excluded HMO State Mandates
TMJ	TMJ
Home Health Care	In vitro
In vitro	
Hearing Aid	

The Consumer Choice Health Benefit Plans may include requirements and/or restrictions on deductibles, coinsurance, copayments, or 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.texas.gov/consumer/index.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:_____

Health Questionnaire for groups enrolling 2-50 employees: (check all that apply)

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 ☐ No ☐ Yes
   - who incurred more than $10,000 of medical expenses in the past 24 months ☐ No ☐ Yes
   - who has been advised within the last 90 days to have surgery or be hospitalized ☐ No ☐ Yes
4. 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 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:

• AIDS or an AIDS-related complex or other immune system disorder	☐ No ☐ Yes	• Diabetes or any disease or disorder of the kidneys, liver or lungs	☐ No ☐ Yes
• Alcohol or drug abuse or dependence, or psychological disorder	☐ No ☐ Yes	• Systemic disease including, but not limited to Lupus, Multiple Sclerosis, or Muscular Dystrophy	☐ No ☐ Yes
• Cancer or cancerous tumor	☐ No ☐ Yes	• Heart or vascular disease or stroke	☐ No ☐ Yes
• Organ transplant (other than corneal)	☐ No ☐ Yes		

If you answered yes to questions 1-4 above, please indicate the question number and explanation. Attach additional signed and dated sheets (reorder TX-52334), if necessary.

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 Class

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.

b. DENTAL PLANS

	Plan 1	Plan 2
Plan name (as shown on your proposal)		
Funding type	☐ Employer sponsored ☐ Voluntary	☐ Employer sponsored ☐ Voluntary
Coinsurance	___% / /	___% / /
Deductible	$	$
Annual maximum	$	$
Preventive services deductible options	☐ Apply deductible ☐ Waive deductible	☐ Apply deductible ☐ Waive deductible
Periodontic/Endodontic options	☐ Basic ☐ Major	☐ Basic ☐ Major
Composite fillings for molars	☐ No ☐ Yes	☐ No ☐ Yes
Implant coverage	☐ No ☐ Yes	☐ No ☐ Yes
Orthodontia options	☐ Child only: lifetime ortho max $ _____ ☐ Adult & child: lifetime ortho max $ _____	☐ Child only: lifetime ortho max $ _____ ☐ Adult & child: lifetime ortho max $ _____
Out of network reimbursement options	☐ Max allowable fee ☐ In-network fee schedule	☐ Max allowable fee ☐ In-network fee schedule
Oral Surgery Covered in Basic	☐ No ☐ Yes	☐ No ☐ Yes
Open Enrollment	☐ No ☐ Yes	

c. LIFE - Please refer to your proposal

Basic Life

Basic Employee Life and AD&D ☐ No ☐ Yes

☐ Flat amount—indicate level: $_____

☐ Salary plan—options are .5x to 7x salary (in .5 increments), rounded to the next highest $1,000. Indicate salary level: _____ x salary
Maximum benefit $_____

☐ Class schedule—no more than 2.5 times between the classes and 10 times between the lowest and highest class (complete table below).

Class	Description	Choose Flat Amount or Salary Level (Must match for all classes)
1.		
2.		
3.		
4.		

Rate Guarantee ☐ 2 Year ☐ 3 Year

Age Reduction (Refer to your proposal) Schedule 1 _____ Schedule 2 _____ Schedule 3 _____

Basic and Voluntary Age Reduction schedules must match.

Basic Dependent Life ☐ No ☐ Yes

If yes, indicate volume amount

☐ Spouse $20,000; Dependent Age 6 Months to 26 Years $5,000, Dependent Age 15 Days to 6 Months $1,000, Birth through 14 Days No Benefit

☐ Spouse $10,000; Dependent Age 6 Months to 26 Years $2,500, Dependent Age 15 Days to 6 Months $500, Birth through 14 Days No Benefit

☐ Spouse $5,000; Dependent Age 6 Months to 26 Years $1,000, Dependent Age 15 Days to 6 Months $500, Birth through 14 Days No Benefit

☐ Spouse $20,000; Dependent Age 6 Months to 26 Years $10,000, Dependent Age 15 Days to 6 Months, $500, Birth through 14 days No Benefit

☐ Spouse $10,000; Dependent Age 6 Months to 26 Years $5,000, Dependent Age 15 Days to 6 Months $500, Birth through 14 Days No Benefit

☐ Spouse $10,000; Dependent Age 6 Months to 26 Years $10,000, Dependent Age 15 Days to 6 Months $500, Birth through 14 Days No Benefit

c. LIFE (continued)

Voluntary Life

Voluntary Employee Life ☐ No ☐ Yes

If yes, do you want to select AD&D? ☐ No ☐ Yes

Flat amount—indicate level: $_____

☐ Minimum amount $_____

☐ Maximum benefit $_____

Voluntary Dependent Life ☐ No ☐ Yes

(Only available if Employee Voluntary Life is chosen)

Dependent Child Voluntary Amount ☐ $5,000 ☐ $10,000

Rate Guarantee ☐ 2 Year ☐ 3 Year

Age Reduction (Refer to your proposal) Schedule 1 _____ Schedule 2 _____ Schedule 3 _____

Basic and Voluntary Age Reduction schedules must match.

Portability of coverage (Applicable to Voluntary Life only) Groups 1-100: Included (Unless mandated by state)

d. VISION PLANS

Plan name (as shown on your proposal)

e. SHORT TERM DISABILITY (group sizes 2-9). Attach additional signed and dated sheets (reorder TX-52336), if necessary.

	Name of Class 1	**Name of Class 2**
Funding type	☐ Contributory ☐ Non-contributory	☐ Contributory ☐ Non-contributory
Benefit schedule (select one)	☐ 60% ☐ Flat amount $ _____	☐ 60% ☐ Flat amount $ _____
Weekly benefit minimum	$25.00	$25.00
Weekly benefit maximum	$	$
Earnings definition	■ Base Salary	■ Base Salary
Duration weeks	☐ 13 ☐ 26	☐ 13 ☐ 26
Injury/Sickness Elimination period (days) (accident/ sickness)	☐ 1/8 ☐ 8/8 ☐ 15/15 ☐ 30/30	☐ 1/8 ☐ 8/8 ☐ 15/15 ☐ 30/30
Pre-existing limitation (months)	■ 3/12	■ 3/12
Eligibility criteria	_____hrs per ☐ week ☐ month ☐ Other____	_____hrs per ☐ week ☐ month ☐ Other____
Rate guarantee	■ 2 Years	■ 2 Years

f. LONG TERM DISABILITY (group sizes 2-9). Attach additional signed and dated sheets (reorder TX-52336), if necessary.

	Name of Class 1	**Name of Class 2**
Funding type	☐ Contributory ☐ Non-contributory	☐ Contributory ☐ Non-contributory
Benefit schedule (select one)	■ 60%	■ 60%
Monthly benefit minimum	■ Greater of $100 or 10% of monthly income loss	■ Greater of $100 or 10% of monthly income loss
Monthly benefit maximum	$	$
Duration	☐ 5 Years ☐ SSNRA	☐ 5 Years ☐ SSNRA
Elimination period	Days: ☐ 90 ☐ 180	Days: ☐ 90 ☐ 180
Definition of disability	Year own occupation: ■ 2	Year own occupation: ■ 2
Pre-existing limitation (months)	■ 12/24	■ 12/24
Mental health and substance abuse limitation	■ 24-month outpatient	■ 24-month outpatient
Rate guarantee	■ 2 Years	■ 2 Years
Survivor income benefit	■ 3 month gross lump sum	■ 3 month gross lump sum

g. SHORT TERM DISABILITY (group sizes 10+) Attach additional signed and dated sheets (reorder TX-52336), if necessary.

Name of Class 1	
Funding type	☐ Contributory ☐ Non-contributory ☐ Voluntary
Benefit schedule (select one)	☐ 50% ☐ 60% ☐ 66.67% ☐ Other _____ ☐ Flat amount $ _____
Weekly benefit minimum	$25.00
Weekly benefit maximum	$
Earnings definition	■ Base Salary
Duration weeks	☐ 13 ☐ 26 ☐ 52 ☐ Other _____
Elimination period (days) (Accident/Sickness)	☐ 1/8 ☐ 8/8 ☐ 15/15 ☐ 30/30 ☐ Other _____
Pre-existing limitation (months)	☐ None ☐ 3/12 ☐ 6/12 ☐ Other _____
Rate guarantee	☐ 1 Year ☐ 2 Years ☐ Other _____

Name of Class 2	
Funding type	☐ Contributory ☐ Non-contributory ☐ Voluntary
Benefit schedule (select one)	☐ 50% ☐ 60% ☐ 66.67% ☐ Other _____ ☐ Flat amount $ _____
Weekly benefit minimum	$25.00
Weekly benefit maximum	$
Earnings definition	■ Base Salary
Duration weeks	☐ 13 ☐ 26 ☐ 52 ☐ Other _____
Elimination period (days) (Accident/Sickness)	☐ 1/8 ☐ 8/8 ☐ 15/15 ☐ 30/30 ☐ Other _____
Pre-existing limitation (months)	☐ None ☐ 3/12 ☐ 6/12 ☐ Other _____
Rate guarantee	☐ 1 Year ☐ 2 Years ☐ Other _____

h. LONG TERM DISABILITY (group sizes 10+) Attach additional signed and dated sheets (reorder TX-52336), if necessary.

Name of Class 1	
Funding type	☐ Contributory ☐ Non-contributory ☐ Voluntary
Benefit schedule (select one)	☐ 50% ☐ 60% ☐ 66.67% ☐ Other _____
Monthly benefit minimum	■ Greater of $100 or 10% of Monthly Income Loss
Monthly benefit maximum	$
Earnings definition	■ Base Salary
Duration	☐ 2 Years ☐ 5 Years ☐ SSNRA ☐ Other _____
Elimination period	Days: ☐ 30 ☐ 60 ☐ 90 ☐ 180 ☐ Other _____
Definition of disability	Year own occupation: ☐ 2 ☐ 3 ☐ to age 65 ☐ Other _____
Pre-existing limitation (months)	☐ 3/3/12 ☐ 6/6/12 ☐ 12/12/24 ☐ 3/6/12 ☐ 6/6/24 ☐ Other _____
Mental health and substance abuse limitation	☐ 24-month outpatient ☐ 12-month outpatient ☐ Other _____
Waiting period: current employees	☐ Eligible on date of employment ☐ Eligible after active employment for _____ days
Waiting period: rehired/new employees	☐ Eligible on date of employment ☐ Eligible after active employment for _____ days
Rate guarantee	☐ 1 Year ☐ 2 Years ☐ Other _____

h. LONG TERM DISABILITY (group sizes 10+) (continued)

Name of Class 2	
Funding type	☐ Contributory ☐ Non-contributory ☐ Voluntary
Benefit schedule (select one)	☐ 50% ☐ 60% ☐ 66.67% ☐ Other _____
Monthly benefit minimum	■ Greater of $100 or 10% of Monthly Income Loss
Monthly benefit maximum	$
Earnings definition	■ Base Salary
Duration	☐ 2 Years ☐ 5 Years ☐ SSNRA ☐ Other _____
Elimination period	Days: ☐ 30 ☐ 60 ☐ 90 ☐ 180 ☐ Other _____
Definition of disability	Year own occupation: ☐ 2 ☐ 3 ☐ to age 65 ☐ Other _____
Pre-existing limitation (months)	☐ 3/3/12 ☐ 6/6/12 ☐ 12/12/24 ☐ 3/6/12 ☐ 6/6/24 ☐ Other _____
Mental health and substance abuse limitation	☐ 24-month outpatient ☐ 12-month outpatient ☐ Other _____
Rate Guarantee	☐ 1 Year ☐ 2 Years ☐ Other _____

Additional benefits: Please refer to your proposal for additional benefits available with plan selected. Attach additional signed and dated sheets (reorder TX-52336), if necessary.

Cost of living adjustment (3%)	☐ No ☐ Yes If Yes, ■ lesser of 3% or 1/2 CPI, select number of adjustments ☐ 5 ☐ 10
Business income protection	☐ No ☐ Yes If Yes, ■ 25% to $5,000
Special conditions limitiation	☐ No ☐ Yes If Yes, ■ 24 months
Survivor income benefit	☐ 3-month gross lump sum ☐ 6-month gross lump sum

i. WORKPLACE VOLUNTARY BENEFITS

DISABILITY INCOME PLUS ☐ No ☐ Yes **Plan design** ☐ Benefits are provided in conjunction with an HSA plan
☐ Benefits will be offered in conjunction with an IRS-qualified pre-tax plan

Benefit period (select all that apply) ☐ 3 Months ☐ 6 Months ☐ 1 Year ☐ 2 Years ☐ 3 Years
Elimination period (select all that apply) (Days) ☐ 0/7 ☐ 7/7 ☐ 0/14 ☐ 14/14 ☐ 30/30 ☐ 60/60
☐ 90/90 ☐ 180/180 ☐ 365/365

Optional Benefits - Employer Selectable ☐ Loss of work ☐ 24-hour coverage ☐ Takeover
☐ Mental, nervous, alcohol and drug abuse ☐ Portability
☐ Sickness elimination period waiver
(available only if 7- or 14-day elimination period is selected for sickness)

Optional Benefits - Employee Selectable ☐ COBRA benefit ☐ Physical Therapy ☐ ICU/CCU

ACCIDENT ☐ Group ☐ Trust **Base Plan** ☐ Level 1 ☐ Level 2 ☐ Level 3 ☐ Level 4
☐ Benefits will be offered in conjunction with an IRS-qualified pre-tax plan

Optional Riders (May not be available with all plans.)
☐ Hospital Intensive Care (per day) ☐ $150 ☐ $300 ☐ $450 ☐ $600 ☐ $900
☐ Fracture and dislocation
☐ Accident total disability (elimination period) ☐ 1 Day ☐ 7 Days ☐ 14 Days ☐ 30 Days
☐ On-the-job coverage ☐ Travel/Lodging ☐ Loss of work

CRITICAL ILLNESS ☐ No ☐ Yes **Plan design** ☐ Benefits are provided in conjunction with an HSA plan
☐ Benefits will be offered in conjunction with an IRS-qualified pre-tax plan

Coverage choices ☐ Vascular ☐ Cancer ☐ Other critical illnesses 50 or 100% of face amount

Optional Benefits - Employer Selectable ☐ Benefit recurrence ☐ Loss of work ☐ Takeover

Optional Benefits - Employee Selectable ☐ Health screening benefit $_____ ☐ Automatic benefit increase

CRITICAL LIFE ☐ No ☐ Yes **Plan design** ☐ 10 Year ☐ 20 Year
Optional Benefits - Employer Selectable ☐ Waiver of premium ☐ Loss of work ☐ Takeover
☐ Additional benefit increase ☐ Accelerated living benefit - critical illness ____%
☐ Accidental death and loss of sight dismemberment

i. WORKPLACE VOLUNTARY BENEFITS (continued)

CANCER ☐ Group Lump Sum Cancer
☐ Benefits will be offered in conjunction with an IRS-qualified pre-tax plan
Optional Benefits - Group Lump Sum Cancer Employer selectable ☐ Benefit recurrence ☐ Loss of work ☐ Takeover benefit
Optional Benefits - Group Lump Sum Cancer Employee selectable ☐ Health Screening $_____
☐ Automatic benefit increase

HOSPITAL INDEMNITY ☐ No ☐ Yes ☐ Benefits will be offered in conjunction with an IRS-qualified pre-tax plan

Base plan	☐ Plan A	☐ Plan B	☐ Plan C	☐ Plan D
Hospital Indemnity	$100/day	$200/day	$300/day	$500/day
Hospital First Occurrence	$250/day	$500/day	$500/day (days 1-2) $750/day (days 3-4)	$500/day (days 1-2) $1,000/day (days 3-4)
Optional benefits - Employer selectable				
☐ ICU/CCU/Burn Unit benefit	$100/day	$200/day	$600/day	$1,000/day

If multiple plans are selected and plan availability is limited by class, please list what class of employees are eligible for each plan.

7. THE FOLLOWING APPLIES TO ALL COMPANIES AND PLANS EXCEPT WORKPLACE VOLUNTARY BENEFITS

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

You, the participating employer, policyholder, contractholder, or Group Contract, Certificate sponsor, intend to establish, sponsor, plan 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.

8. THE FOLLOWING APPLIES TO ALL COMPANIES AND PLANS

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

If you fail to pay premium when due, coverage may be subject to termination as specified under the terms of the Policy, Group Contract,or Certificate.

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. You will receive advance written notice.

For you to remain eligible for the Policy, Group Contract, or Certificate, the eligibility, underwriting, participation, and contribution requirements must be maintained, for each respective coverage.

Failure to maintain the plan eligibility, underwriting, participation and contribution requirements will terminate your coverage under the Policy, Group Contract, or Certificate.

We have the right to use information provided by you and any applicant (employee or dependent) to determine eligibility and establish appropriate premiums to the extent permitted by law. Based upon our standard underwriting practice, we may require an employee or dependent to submit Evidence of Health Status. We will not use health related information to decline coverage.

9. AGREEMENT AND SIGNATURE - Review your policy/certificate /group contract carefully

You the employer, policyholder, contract holder, or group contract sponsor understand, agree and represent: You have read this Employer/Group Application (EGA) and the information you provided is accurate and complete to the best of your knowledge and belief and can be substantiated by your business records. You have received and reviewed the quote and the applicable required regulatory information. 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. For action to be taken on this EGA, the first month's estimated premium and fully completed enrollment information for all employees and dependents must be submitted with the EGA. You may be charged a monthly administrative fee which will not be more than $5.00 per month per covered employee based on coverage selected. Coverage is not in effect unless and until you receive written notification from us. You will provide the documentation requested by us which establishes that all eligibility, underwriting, and participation requirements of the plan are met. 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. Providing incomplete, inaccurate, or untimely information may void, reduce, or increase past premium, or terminate an individual's coverage or the group's coverage. This EGA will form part of any contract or coverage issued. If this EGA is declined, we will return the premium deposit submitted with this application. 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. 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).

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 you decide not to sign this EGA, we will decline to enroll you in an insurance product or to give you insurance benefits.

DO NOT CANCEL ANY CURRENT GROUP COVERAGE UNTIL YOU RECEIVE WRITTEN NOTICE FROM US THAT WE HAVE ISSUED COVERAGE.

Dated on: _____ (month, date, year) at _____ (city and state)

By: _____ _____ _____

(Employer printed name) (Employer signature) (Title)

For Workplace Voluntary Benefits - only necessary for non-employer groups.

By: _____ _____ _____

(Plan sponsor printed name) (Plan sponsor signature) (Title)

10. AGENT/BROKER/PRODUCER INFORMATION

1. Agency of Record (for commissions and correspondence)	**2. 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: (total should equal 100%)	Commission split ☐ No ☐ Yes If yes, percentage: (total should equal 100%)
1. Writing Agent/Broker/Producer	**2. Writing Agent/Broker/Producer**
Name (print or type)	Name (print or type)
Social Security Number/Humana Agent Number	Social Security Number/Humana Agent Number
Commission split ☐ No ☐ Yes If yes, percentage: (total should equal 100%)	Commission split ☐ No ☐ Yes If yes, percentage: (total should equal 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/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 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. 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 Guide or other plan literature.

Writing Agent/Broker/Producer's Signature:_____ Date:_____