

# Humana Small Group Medical

**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: \$ _____ Non-participating: \$ _____	Participating: \$ _____ Non-participating: \$ _____	Participating: \$ _____ Non-participating: \$ _____
<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>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

**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.
- If less than 50 employees are enrolled, you must submit evidence of health status for all employees and dependents. We will not use the evidence of health status to decline medical coverage.
- Minimum employer contribution toward employee premium is 50%.
- Retiree coverage is available to employers with 26 or more enrolled employees.
- Minimum age for retiree coverage is 65 for employers with 26 to 50 enrolled employees.
- 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**

- non-contributory plans – 100%
- contributory plans – 75%

**Group Information**

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

Do you wish to have 24-hour coverage for employees not covered by Workers' Compensation?  No  Yes  
If yes, name(s): \_\_\_\_\_

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:

<b>Current Plan 1 current carrier rates:</b>	<b>Current Plan 2 current carrier rates:</b>
Employee: \$ _____ Spouse: \$ _____	Employee: \$ _____ Spouse: \$ _____
Child(ren): \$ _____ Family: \$ _____	Child(ren): \$ _____ Family: \$ _____
Plan design: _____	Plan design: _____
Office visit copay: _____	Office visit copay: _____
Per confinement copay: _____	Per confinement copay: _____
Deductible:      • Participating _____ • Non-participating _____	Deductible:      • Participating _____ • Non-participating _____
Out-of-pocket:    • Participating _____ • Non-participating _____	Out-of-pocket:    • Participating _____ • Non-participating _____
Coinsurance stoploss: • Participating _____ • Non-participating _____	Coinsurance stoploss: • Participating _____ • Non-participating _____
Emergency room copay: _____	Emergency room copay: _____
Prescription drug benefit: _____	Prescription drug benefit: _____
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? _____	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? _____
<b>Renewal rates:</b> In the parentheses, please indicate the number of employees enrolled in each tier, if available. Employee ( ): \$ _____ Spouse ( ): \$ _____ Child(ren) ( ): \$ _____ Family ( ): \$ _____	<b>Renewal rates:</b> In the parentheses, please indicate the number of employees enrolled in each tier, if available. Employee ( ): \$ _____ Spouse ( ): \$ _____ Child(ren) ( ): \$ _____ Family ( ): \$ _____

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: