



HUMANA®

**HUMANA MULTI-LOCATION
EMPLOYER GROUP INFORMATION**

Home Office Information		Group Number
DBA Name of Company		<input type="checkbox"/> Primary site multi-location <input type="checkbox"/> Various site multi-location <input type="checkbox"/> Simplified multi-location <input type="checkbox"/> Simplified primary site <input type="checkbox"/> Simplified various site <input type="checkbox"/> Other affiliation
Legal Name of Company		
County	State	
<input type="checkbox"/> Bill all group numbers together. (Smaller locations will be simplified, i.e. combined with the main location.) <input type="checkbox"/> Bill each group number separately. Additional billing fees may apply.		

INSTRUCTIONS

- Various site accounts do not need to complete the rest of the form.
- All other accounts, please complete the information below for each quoted working location. Only complete plan information if different from this employer's main location.
- Group numbers will be completed by sales office staff, if appropriate.

Working Location 1			
Name of Location, if different:			Group Number
Street Address			County
City	State	Zip	Contact Name:
Medical Plan - If Applicable Plan Name: _____ Network: _____ Deductible In/Out of Network: _____ / _____ Coinsurance Limit In/Out of Network: _____ / _____ Out of Pocket Amount In/Out of Network: _____ / _____ Pharmacy Benefit: _____ Optional Benefits: _____ _____			Phone Number: # Enrolled Employees:* Dental Plan Life Plan

Working Location 2			
Name of Location, if different:			Group Number
Street Address			County
City	State	Zip	Contact Name:
Medical Plan - If Applicable Plan Name: _____ Network: _____ Deductible In/Out of Network: _____ / _____ Coinsurance Limit In/Out of Network: _____ / _____ Out of Pocket Amount In/Out of Network: _____ / _____ Pharmacy Benefit: _____ Optional Benefits: _____ _____			Phone Number: # Enrolled Employees:* Dental Plan Life Plan

*If more than one line of coverage is applied for, count only employees enrolled in the primary coverage. Primary coverage is generally medical, or dental if there is no medical.

Working Location 3			
Name of Location, if different:			Group Number
Street Address			County
City	State	Zip	Contact Name:
Medical Plan - If Applicable			Phone Number:
Plan Name: _____			# Enrolled Employees:*
Network: _____			
Deductible In/Out of Network: _____/_____			Dental Plan
Coinsurance Limit In/Out of Network: _____/_____			
Out of Pocket Amount In/Out of Network: _____/_____			Life Plan
Pharmacy Benefit: _____			
Optional Benefits: _____ _____			

Working Location 4			
Name of Location, if different:			Group Number
Street Address			County
City	State	Zip	Contact Name:
Medical Plan - If Applicable			Phone Number:
Plan Name: _____			# Enrolled Employees:*
Network: _____			
Deductible In/Out of Network: _____/_____			Dental Plan
Coinsurance Limit In/Out of Network: _____/_____			
Out of Pocket Amount In/Out of Network: _____/_____			Life Plan
Pharmacy Benefit: _____			
Optional Benefits: _____ _____			

Working Location 5			
Name of Location, if different:			Group Number
Street Address			County
City	State	Zip	Contact Name:
Medical Plan - If Applicable			Phone Number:
Plan Name: _____			# Enrolled Employees:*
Network: _____			
Deductible In/Out of Network: _____/_____			Dental Plan
Coinsurance Limit In/Out of Network: _____/_____			
Out of Pocket Amount In/Out of Network: _____/_____			Life Plan
Pharmacy Benefit: _____			
Optional Benefits: _____ _____			

*If more than one line of coverage is applied for, count only employees enrolled in the primary coverage. Primary coverage is generally medical, or dental if there is no medical.