Humana Risk Assessment

Please answer the following questions to the best of your knowledge in accordance with your company records.

Internal use only

Humana sales office: _____

Quote number: _____

Sales representative: _____

Broker name: _____

Is this the agent of record? ❍ No ❍ Yes
If yes, how long?

Group Information

Company name | SIC code

Do you have a current health care carrier? ❍ No ❍ Yes
If yes, carrier name: | Renewal date:

Number of employees eligible for coverage under your current plan:

Number of employees enrolled in your current plan:

How much will you contribute to premium? Employee _____% Dependent _____%

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

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

Current Plan 1	**Current Plan 2**
Plan Design: ❍ HMO ❍ PPO ❍ POS	**Plan Design:** ❍ HMO ❍ PPO ❍ POS
Current carrier rates:	**Current carrier rates:**
Employee: $_____ Spouse: $_____	Employee: $_____ Spouse: $_____
Child(ren): $_____ Family: $_____	Child(ren): $_____ Family: $_____
Plan design (i.e. 90/70):	Plan design (i.e. 90/70):
Office visit copay:	Office visit copay:
Deductible: • Participating _____ • Non-participating _____	Deductible: • Participating _____ • Non-participating _____
Out-of-pocket: • Participating _____ • Non-participating _____	Out-of-pocket: • Participating _____ • Non-participating _____
Prescription drug benefit:	Prescription drug benefit:
Renewal rates: In the parentheses, please indicate the number of employees enrolled in each tier, if available.	**Renewal rates:** In the parentheses, please indicate the number of employees enrolled in each tier, if available.
Employee ( ): $_____ Spouse ( ): $_____	Employee ( ): $_____ Spouse ( ): $_____
Child(ren) ( ): $_____ Family ( ): $_____	Child(ren) ( ): $_____ Family ( ): $_____

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;

Continued...

Group Information (continued)

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: (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 1-4 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 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 partially self-funded or self-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 early retirees? ❍ No ❍ Yes If yes, how many?

COBRA Information

How many employees with COBRA continuation coverage will enroll?

Disclosure and Signature

Under no circumstances should the group cancel their present group insurance coverage without written notice of approval from Humana Inc. This risk assessment is intended to help Humana underwrite the group's request for group insurance. Additional information may be required on employees who are required to answer medical questions for any conditions not disclosed on this form. This information could potentially impact underwriting's final decision.

Completed by: _____ Title: _____

Date: _____

The broker representing this group certifies that this information is complete and accurate according to the broker's knowledge of the health conditions for this group's employees and their dependents. If the broker has any additional information, please attach a signed and dated addendum.

Broker signature: _____ Date: _____

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Guidance when you need it most