

# Humana Small Group Medical

Please refer to your proposal to complete this application. This document will form part of any contract issued. Print clearly in black ink, and answer all questions or indicate "not applicable".

**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>Deductible Carryover Credit</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>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
<b>Waive Behavioral Health</b> (only available for 51-99)	<input type="radio"/> No <input type="radio"/> Yes PMPM \$ _____	<input type="radio"/> No <input type="radio"/> Yes PMPM \$ _____	<input type="radio"/> No <input type="radio"/> Yes PMPM \$ _____
<b>Catastrophic Mental Health</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>Serious Mental Illness</b> (only available if Catastrophic Mental Health is purchased)	<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.
- A one time surcharge equal to 25% of annual premium will be assessed to any maximum rated small group that is moving off annual anniversary.

**Participation**

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

**Group Information**

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

**Group Information (continued)**

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

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

Date of renewal: \_\_\_\_\_

Current Plan 1 current carrier rates:	Current Plan 2 current carrier rates:
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: <ul style="list-style-type: none"> <li>• Participating _____</li> <li>• Non-participating _____</li> </ul>	Deductible: <ul style="list-style-type: none"> <li>• Participating _____</li> <li>• Non-participating _____</li> </ul>
Out-of-pocket: <ul style="list-style-type: none"> <li>• Participating _____</li> <li>• Non-participating _____</li> </ul>	Out-of-pocket: <ul style="list-style-type: none"> <li>• Participating _____</li> <li>• Non-participating _____</li> </ul>
Coinsurance stoploss: <ul style="list-style-type: none"> <li>• Participating _____</li> <li>• Non-participating _____</li> </ul>	Coinsurance stoploss: <ul style="list-style-type: none"> <li>• Participating _____</li> <li>• Non-participating _____</li> </ul>
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 ( ): \$ _____

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;
- 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)

### Group Information (continued)

If you answered yes to questions 1-3 on the previous page, 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 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: \_\_\_\_\_

Which plan(s) are you offering?  Medicare + Choice  Other (list plan): \_\_\_\_\_

Do you wish to offer coverage to dependents of retirees? (Medicare + Choice not available?)  No  Yes

Who should receive the premium bill?  Employer  Retiree