

**Internal use only**  
Group number:

# Employer Group Application

**ILLINOIS  
HUMANA / HUMANADENTAL / COMPBENEFITS**

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."

## Your Business Profile

Business name \_\_\_\_\_ Federal tax ID number \_\_\_\_\_

Location address (not a P.O. Box) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_ County \_\_\_\_\_

Do you have more than one location?  No  Yes

Billing address (if different) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_ County \_\_\_\_\_

Nature of business or SIC number \_\_\_\_\_ Date company established \_\_\_\_\_

Business status:  Corporation  Partnership  Sole Proprietorship  Other: (explain) \_\_\_\_\_

Business phone number \_\_\_\_\_ Fax number \_\_\_\_\_

Management contact \_\_\_\_\_ Administrative contact \_\_\_\_\_

Management contact e-mail address \_\_\_\_\_

Management contact: Mother's maiden name \_\_\_\_\_  
*This will be used to gain access to the Employer Self-Service Center on www.Humana.com.*

## General Eligibility

Requested effective date \_\_\_\_\_ How many employees are on your payroll? \_\_\_\_\_

How many hours per week must your employees work to be eligible? (select between 20 and 40 hours) \_\_\_\_\_

Do you want to exclude a class of employees?  No  Yes  
If yes, check class to exclude: (Options vary by plan. Refer to the Underwriting Requirements for each plan.)  
 union  non union  hourly  salary  management  non-management

How long must employees wait after hire date to become eligible?  0 days  30 days  60 days  90 days  
 Other, specify: \_\_\_\_\_

How many employees are eligible for coverage? \_\_\_\_\_

New employee effective date provision:  First of month following waiting period (required for Medical HMO or Prepaid Dental plans)  
 Immediately following waiting period  
On all plans, the employee termination date coincides with the effective date provision.

Is this employer required to comply with COBRA regulation?  No  Yes

Is this employer required to comply with state continuation regulation?  No  Yes

Are any present or former employees/dependents currently on or eligible to elect COBRA/State Continuation?  No  Yes  
If yes, enter information below. Attach a separate sheet if necessary.

Name of applicant	Qualifying event (e.g., termination of employment, divorce, etc.)	Date of qualifying event	Date COBRA or State Continuation coverage terminates

## Employer Agreement

You the employer, understand, agree and represent:

- You have read this document 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 a proposal and the applicable regulatory information required by your state.
- Neither you nor the agent/broker/producer 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.
- The first month's estimated premium (which may include a monthly administrative fee), and fully completed enrollment information for all eligible persons requesting insurance coverage must be submitted with this application before action is taken on this application. Unless we are informed differently, we will perform a one-time electronic check conversion of the first month's premium payment from the account and for the amount designated on the binder check.
- You will collect any employee contribution toward premium. Our acceptance of premium does not guarantee coverage.
- You will provide the documentation requested by us which establishes that all eligibility, underwriting, and participation requirements of the plan are met.
- Only individuals who meet the eligibility requirements of the plan are eligible to maintain coverage.
- Providing incomplete, inaccurate, or untimely information may void, reduce, or increase past premium, or terminate an individual's coverage or the group's coverage.
- If choosing the HDHP Indexing plan, deductible and out of pocket amounts are established by IRS guidelines. Adjustments to these amounts by the IRS will be made to the policy, without notice, upon renewal of the group.

This document will form part of any contract issued. Coverage is not in effect unless and until you receive written notification from us.

If this application is declined, we will return the premium deposit submitted with this application.

**Do not cancel any current group coverage until you receive written notice from us that we have issued coverage.**

Dated on: \_\_\_\_\_  
(month, date, year)

By: \_\_\_\_\_  
(employer signature)

Dated at: \_\_\_\_\_  
(city and state)

By: \_\_\_\_\_  
(title)

## Agent/Producer Information

1. Agent/Agency of Record (for commissions and correspondence):	2. Agent/Agency of Record (for split-commissions):
Name (print)	Name (print)
Tax ID / Social Security Number / Humana Agent Number	Tax ID / Social Security Number / Humana Agent Number
Commission split: <input type="radio"/> No <input type="radio"/> Yes If yes, percentage: (total should equal 100%)	Percentage of sales: <input type="radio"/> No <input type="radio"/> Yes If yes, percentage: (total should equal 100%)
<b>1. Writing Agent/Producer:</b>	<b>2. Writing Agent/Producer:</b>
Name (print)	Name (print)
Social Security Number	Social Security Number
Commission split: <input type="radio"/> No <input type="radio"/> Yes If yes, percentage: (total should equal 100%)	Percentage of sales: <input type="radio"/> No <input type="radio"/> Yes If yes, percentage: (total should equal 100%)

## General Agency

General agency information pertains to  Agent/Agency of Record #1  Agent/Agency of Record #2

Name (print)

Tax ID / Humana Agent Number

Address

City

State

Zip code

As the Writing Agent/Producer, I acknowledge that I am responsible to meet with the employer submitting this 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. These provisions are available to me and the employer in the Regulatory Pre-enrollment Disclosure or other plan literature.

Writing Agent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## The following applies to all companies and products

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

You, the participating employer, policyholder, contractholder, or group plan sponsor, intend to establish, 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.

Small employer means a person, firm, corporation, partnership or association actively engaged in business, which employed an average of at least two but not more than 50 employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year, unless otherwise provided under the state law. Entities that are affiliated companies or that are eligible to file a combined tax return for the purpose of taxation, are considered one employer.

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

As claims administrator with authority to make claim determinations as described in Section 503 of ERISA, we may make decisions under the Policy or Group Plan with respect to determining eligibility for coverage and paying claims for benefits, including deciding appeals of denied claims.

You understand and agree that failure to remit and pay premium when due will be considered a default in premium payment, and that coverage will be terminated by us, following a grace period of 31 days from the date of non-payment of premium. We may terminate your coverage according to the termination section of the Policy or Group Plan. Except for non-payment of

premium or when a group or individual is not or has not been eligible for coverage, you will be provided with a 30 day advance written notice, unless a greater period is expressly specified in the Policy. If coverage is terminated by us for non-payment of premium, you will still owe and we will collect all due premium including premium for the grace period.

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, after your insurance has been in effect under the Policy for six consecutive months. You will receive advance written notice.

For you to remain eligible for the Policy or Group Plan, the eligibility, underwriting and participation requirements must be maintained, for each respective coverage. Failure to maintain the plan eligibility, underwriting and participation requirements will terminate your coverage under the Policy or Group Plan. Other termination provisions are stated in the Policy or Group Plan. Based upon our standard underwriting practice, we may require an employee or dependent to submit Evidence of Health Status. We have the right to use the information provided by you and any applicant (employee or dependent) to determine whether coverage will be provided, to determine eligibility and to establish appropriate premiums. Any health related information that has been provided will not be used to decline medical coverage unless permitted by law.

## The following applies to medical products insured by Humana Insurance Company

You, the participating employer, apply to participate in the Employers Health Insurance Benefits Trust (No. 1 and/or No. 3) for insurance coverage, which may be modified from time to time, as underwritten by us.

If you are accepted, you acknowledge and agree on behalf of all persons who obtain insurance coverage through or under your application to the Trust, that the Trust Agreement, the provisions of the Trust, or any other written instrument the trustee signs on behalf of the Trust are fully binding upon you. The principal duties of the trustee are to hold the insurance policy(ies) through which insurance coverage is provided for employers in accordance with the terms of

the Trust Agreement or any other written instrument which the trustee signs on behalf of the Trust.

The Trust Agreement, any other written instrument and the insurance policy(ies), are available for inspection by you or by any covered person through or under your participation in the Trust, during normal business hours at our home office. You further understand and agree that the Trust and Trustee are not insurers. You may withdraw from the Trust at any time subject to certain premium obligations described in the Employer Agreement section, thus terminating your insurance coverage, provided written notice of termination is received by us prior to the requested termination date.

**HUMANA**<sup>®</sup>  
*Guidance* when you need it most

HMO plans offered by Humana Health Plan, Inc. PPO, Classic medical plans, Life and Short-Term Income Protection plans insured or administered by Humana Insurance Company.

**HUMANA**<sup>®</sup>  
*Specialty Benefits*

Dental PPO and Traditional Preferred plans insured or administered by HumanaDental Insurance Company or Humana Insurance Company. Dental prepaid plans and AdvantagePlus dental plans offered and administered by CompBenefits Dental, Inc. CompBenefits Vision plan insured and administered by CompBenefits Insurance Company.