Internal use only
Group number:

Employer Group Application

TEXAS
HUMANA / HUMANADENTAL / COMPBENEFITS

You have the option to choose this Consumer Choice of Benefits Health Insurance Plan that, either in whole or in part, does not provide state-mandated health benefits normally required in accident and sickness insurance policies in Texas. This standard health benefit plan may provide a more affordable health insurance policy for you although, at the same time, it may provide you with fewer health benefits than those normally included as state-mandated health benefits in policies in Texas. If you choose this standard health benefit plan, please consult with your insurance agent to discover which state-mandated health benefits are excluded in this policy.

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.

All Certificate(s) of Insurance/Evidence(s) of coverage are available to you and your employees on our Web site, www.humana.com. If you would also like to receive a paper copy of this information, you must fill in the circle below.

❍ I wish to receive paper copies of Certificate(s) of Insurance/Evidence(s) of Coverage.

General Eligibility

Requested effective date | How many employees are on your payroll?

How many hours per week must your employees usually work to be eligible? (select between 20 and 30 hours)

For groups of 51-99: Do you want to exclude a class of employees? ❍ No ❍ Yes

If yes, check class to exclude: (Options may not be available for all plans. 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 (groups of 2-50 may not exceed 90 days) ❍ Other, specify:

How many employees are eligible for coverage?

New employee effective date provision: ❍ First of month following waiting period (required for HMO, POS and DHMO plans) ❍ Immediately following waiting period

On all plans, the employee termination date coincides with the effective date provision.
When offering multiple choice plans, the waiting period and effective date must be the same on all plans.

Is this employer required to comply with COBRA 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 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.
- For small employers, you may be charged a monthly administrative fee which will not be more than $5.00 per person based on coverage selected. For large employers, you may be charged a monthly administrative fee.
- 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 or group contract are met.
- Only individuals who meet the eligibility requirements of the plan are eligible to maintain coverage.
- For medical coverage, you understand that providing fraudulent information or intentional misrepresentation of a material fact including providing incomplete, inaccurate information may void, reduce, or terminate an individual's coverage or the group's coverage. (Health related factors will not be used to void or terminate an individual's medical coverage or a small employer 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.
- The agent/broker/producer has explained to me that Humana has made available to my firm the State Medical Plans prescribed by Texas House Bill 1212, providing that my firm, as defined in the Act, is a small employer of 2-50 eligible employees (this paragraph not applicable to large employers).

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

For large employers, 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:_____ By:_____
(month, date, year) (employer signature)

Dated at:_____ By:_____
(city and state) (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: ❍ No ❍ Yes If yes, percentage: (total should equal 100%)	Percentage of sales: ❍ No ❍ Yes If yes, percentage: (total should equal 100%)
1. Writing Agent/Producer:	**2. Writing Agent/Producer:**
Name (print)	Name (print)
Social Security Number	Social Security Number
Commission split: ❍ No ❍ Yes If yes, percentage: (total should equal 100%)	Percentage of sales: ❍ No ❍ 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/Broker/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, including an explanation of the State Medical Plans to employers of 2-50 eligible employees. 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.

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, we shall, in accordance with state and federal law, 1) interpret Policy, Group Plan, or Group Contract provisions, 2) make decisions regarding eligibility for coverage and benefits, and 3) resolve factual questions relating to coverage and benefits.

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, Group Plan or Group Contract. 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, Group Plan or Group Contract, the eligibility, underwriting and participation requirements must be maintained, for each respective coverage. Failure to maintain the plan eligibility and underwriting requirements will terminate your coverage under the policy. If you fail the meet the participation requirements for 6 consecutive months, your coverage will be terminated on the first renewal date following the end of this 6-month period. Other termination provisions are stated in the Policy, Group Plan or Group Contract.

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 of an individual or medical coverage of a small employer.

The following applies to medical plans only

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.

HUMANA®
Guidance when you need it most

PPO and Classic Medical plans, Life, Vision and Short-Term Income Protection plans insured or administered by Humana Insurance Company. HMO plans offered by Humana Health Plan of Texas, Inc., a Health Maintenance Organization. POS plans offered by Humana Health Plan of Texas, Inc., a Health Maintenance Organization and insured or administered by Humana Insurance Company.

HUMANA®
Specialty Benefits

Prepaid and AdvantagePlus dental benefits offered and administered by DentiCare, Inc. (d/b/a CompBenefits). All other Dental plans insured or administered by HumanaDental Insurance Company or Humana Insurance Company. CompBenefits Vision plan insured and administered by CompBenefits Insurance Company.

Texas House Bill 2015 Amendment

This Amendment is entered into by and among _____ (hereinafter "Employer") and _____ (hereinafter "Humana").

Witnesseth

WHEREAS, Humana and Employer entered into an insured service agreement (hereinafter "Agreement"), effective _____/_____/_____ (effective date of original service agreement), Humana and Employer desire to amend the Agreement as follows:

Employer hereby amends and certifies that the documents and materials for its group health plan (hereinafter "Plan Documents") will comply with the requirements of 45 C.F.R. 164.504 (f)(2) and that the Employer will safeguard and limit the use and disclosure of protected health information that the Employer may receive from Humana to perform the plan administration functions.

The requirements of 45 C.F.R. 164.504 (f)(2) include, but are not limited to the following provisions:

- Employer shall not use or disclose member information other than as permitted or required by the Plan Documents or as required by law;
- Employer ensures that any agents, including a subcontractor, to whom it provides member information received from the group health plan agrees to the same restrictions and conditions that apply to the Employer;
- Employer shall not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan;
- Employer shall report to the group health plan when it becomes aware of any use or disclosure of the information that is inconsistent with the purpose for which the uses or disclosures were provided to the Employer;
- Employer shall make available the designated record set of protected health information to members for the purposes of inspection pursuant to HIPAA requirements
- Employer shall make available protected health information for amendment and incorporate any amendments to protected health information;
- Employer shall make available the information required to provide an accounting of disclosures;
- Employer shall make its internal practices, books, and records relating to the use and disclosure of protected health information received from the group health plan available to the Secretary of Health and Human Services for purposes of determining compliance by the group health Employer with this subpart;
- Employer shall return or destroy all protected health information received from the group health plan that the sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. [except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible]; and
- Provide for adequate separation between the Employer and the plan sponsor. The Employer documents were amended to:
  - Describe those employees or classes of employees or other persons under the control of the Employer to be given access to the protected health information, provided that any employee or person who receives protected health information pertaining to the Employer's membership in the ordinary course of business must be included in such description;
    - Define employees authorized to receive protected health information:

	Individual 1	Individual 2
Name (First, Last)		
Title		
Address		
City / State / Zip		
Telephone		
Fax		
Email address		

(Note: please include any additional recipients on a separate sheet)

- Restrict the access to and use by such employees and other persons described in paragraph to the plan administration functions that the plan sponsor performs for the Employer; and
- Provide an effective mechanism for resolving any issues of noncompliance by persons with the Plan Documents' provisions required by this paragraph.

Except as specifically amended hereby, the terms and conditions of the Plan Documents remain the same.

The parties have the authority necessary to bind all of the entities identified herein and have executed this Amendment to be effective as of (effective date of Amendment) _____/_____/_____.

IN WITNESS WHEREOF, the parties hereto have duly executed this Agreement.

Employer signature: _____

Print name_____

Title: _____

Date: _____/_____/_____

Humana signature: _____

Print name_____

Title_____

Date: _____/_____/_____

Texas House Bill 2015 Certification

Pursuant to Texas House Bill 2015, _____ (hereinafter "Employer/Plan Sponsor") seeks to obtain certain Protected Health Information (hereinafter "PHI" as the term is defined under 45 C.F.R 164.501) from _____ (hereinafter "Humana"). Employer/Plan Sponsor hereby certifies that the plan documents comply with the requirements of 45 C.F.R. 164.504 (f)(2) and that the Employer/Plan Sponsor will safeguard and limit the use and disclosure of protected health information that the Employer/Plan Sponsor may receive from Humana to perform the plan administration functions.

This certification is effective as of (day) _____ of (month) _____, (year) _____.

Authorized signee: _____ Print name: _____

Title: _____ Date: _____ / _____/_____

2-99 eligible employees

Humana Small Group Medical

TEXAS
EMPLOYER GROUP APPLICATION

Humana Insurance Company
Humana Health Plan of Texas, Inc.

HMO Premium Billing Address
12296 Collections Center Drive
Chicago, IL 60693

Plan Selection (To complete this information, refer to your proposal.)

	Plan 1	Plan 2	Plan 3
Plan name (as shown on your proposal)			
Office visit copayment (if applicable)	$	$	$
Coinsurance (if applicable)	Participating (In) : %_____ Non-participating (Out): % _____	Participating (In) : %_____ Non-participating (Out): % _____	Participating (In) : %_____ Non-participating (Out): % _____
Deductible (if applicable)	Participating (In): $ Non-participating (Out): $	Participating (In): $ Non-participating (Out): $	Participating (In): $ Non-participating (Out): $
Out-of-pocket limit (if applicable)	Participating: $ Non-participating: $	Participating: $ Non-participating: $	Participating: $ Non-participating: $
Network name (if applicable)			

Plan Riders (Please refer to your proposal for rider availability with plan selected.)

	Plan 1	Plan 2	Plan 3
Deductible Carryover Credit	❍ No ❍ Yes	❍ No ❍ Yes	❍ No ❍ Yes
Supplemental Accident	❍ No ❍ Yes	❍ No ❍ Yes	❍ No ❍ Yes
Prescription Drug/Retail Card (Level 1 / 2 / 3 / 4)	$_____ /$_____ /$_____ /_____%	$_____ /$_____ /$_____ /_____%	$_____ /$_____ /$_____ /_____%
Prescription Drug/Retail Card (Group A / B / C / D)	$____a /$____a /$____a /$____a	$____a /$____a /$____a /$____a	$____a /$____a /$____a /$____a
Other:	❍ No ❍ Yes	❍ No ❍ Yes	❍ No ❍ Yes
Special State Options (not available with Consumer Choice Plans)		**PPO and Classic Products**	**HMO and POS Products**
Invitro Fertilization Benefit	❍ No ❍ Yes	Optional	Optional
Serious Mental Illness Benefit	❍ No ❍ Yes	Optional	Included
If your group is a municipality, county, school district or other political subdivision of the state, this benefit must be provided.			
Speech and Hearing Rider	❍ No ❍ Yes	Included	Optional

Consumer Choice Medical Plans

You have the option to choose the Consumer Choice PPO Benefits Health Plan, Consumer Choice HMO Benefits Health Plan, or the Consumer Choice POS Benefits Health Plan that either in whole or in part, does not provide state-mandated health benefits normally required in Texas health benefit plans. A consumer choice standard health benefit plan may provide more affordable health benefits for you and your employees although, at the same time, it may provide you and your employees fewer health benefits than those normally included as state-mandated health benefits in Texas health benefit plans. If you choose a consumer choice standard benefit plan, please consult with your insurance agent to discover which state-mandated health benefits are reduced and/or excluded.

Consumer Choice PPO: ❍ No ❍ Yes

Consumer Choice HMO: ❍ No ❍ Yes

Consumer Choice POS: ❍ No ❍ Yes

Plan Selection (continued)

Below is the Required Disclosure Notice for Group PPO & HMO Consumer Choice Benefit Plans Issued in Texas. To obtain a copy of the required Consumer Choice Disclosure Notice for Consumer Choice POS Benefit Plans Issued in Texas, please consult your insurance agent.

I acknowledge the Consumer Choice PPO Benefits Health Plan, Consumer Choice HMO Benefits Health Plan, or the Consumer Choice POS Benefits Health Plan that either in whole or in part, does not provide state-mandated health benefits normally required in Texas health benefit plans. I am aware a consumer choice standard benefit health plan may provide more affordable health benefits although, at the same time, it may provide fewer health benefits than those normally included as state-mandated health benefits in Texas health benefit plans.

Excluded PPO State Mandates	Excluded HMO State Mandates
Chemical & Alcohol Dependency	Chemical & Alcohol Dependency
TMJ	Oral Contraceptive Drugs & Devices
Home Health Care	TMJ
Serious Mental Illness	Serious Mental Illness
Invitro	Invitro
Speech & Hearing	

The Consumer Choice Health Benefit Plans may include requirements and/or restrictions on deductibles, coinsurance, copayments, or annual or lifetime maximum benefit amounts that differ from other PPO & HMO plans. I understand that I may obtain from the Department of Insurance a consumer brochure with more information on Consumer Choice Health Benefit Plans, either by visiting the TDI website at www.tdi.state.tx.us/consumer/indexc.html, or by calling 1-800-252-3439.

(Only sign and complete this section if a Consumer Choice Plan was selected.)

I acknowledge that I was offered the opportunity to apply for an accident and sickness insurance policy or evidence of coverage in the same category that most closely approximates the consumer choice health benefit plan offered.

Group Representative Signature:_____

Title:_____ Date Signed:_____

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.
- Minimum employer contribution toward employee premium is 50%.
- Retirees of a small employer are not eligible for retiree coverage.
- 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

- All plans – 75%

Group Information

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

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:

Current Plan 1 current carrier rates:	**Current Plan 2 current carrier rates:**
Employee: $_____ Spouse: $_____ Child(ren): $_____ Family: $_____	Employee: $_____ Spouse: $_____ 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? ❍ No ❍ 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? ❍ No ❍ Yes If yes, how much of the deductible do you fund?_____
Renewal rates: In the parentheses, please indicate the number of employees enrolled in each tier, if available. Employee ( ): $_____ Spouse ( ): $_____ Child(ren) ( ): $_____ Family ( ): $_____	**Renewal rates:** 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)

If you answered yes to questions 1-3 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*

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: