

Humana Employer Group Plan Enrollment Instructions

This is easier than it looks, most pages do not need to be complete - just follow the directions.

1. Employer Application

- Complete page 1, section 1 only
- Sign and date page 5
- Return all pages
- When we receive it, we'll call you to complete the rest of the required information.
- We will then send a copy of the completed form for your records

2. Small Employer Certification + Summary of Benefits and Coverage Attestation

- Sign and Date both forms

Return all pages to Toni@HealthPlanStore.com
or fax to 404-575-1967

Employer Group Application (all group sizes)



GEORGIA

Humana.com

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in this Employer Group Application as “Humana”, “We”, “Us”, or “Our”.

HMO and POS plans offered by Humana Employers Health Plan of Georgia, Inc., and/or insured or administered by Humana Insurance Company. PPO and Indemnity Medical plans and Life plans insured or administered by Humana Insurance Company. Dental plans insured or administered by HumanaDental Insurance Company, or Humana Insurance Company. PrePaid Dental Plans offered by Humana Employers Health Plan of Georgia, Inc. Vision plans insured or administered by HumanaDental Insurance Company or Humana Insurance Company.

1. GROUP INFORMATION - Please type or print clearly in black ink

Group number: _____

Group name:				Requested effective date __/__/____	
Corporate/Situs location street address:		City:	State:	ZIP code:	County:
Date company established (MM/DD/YYYY):	Federal Tax ID:	Nature of business/SIC code:		Phone number:	
Benefit Administrator/management contact name:					
Phone number:			Email address:		
Billing contact name:					
Billing address (N/A if same as street address):			City:	State:	ZIP code:
Phone number:			Email address:		
Are separate divisions/classes required for billing or reporting? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please explain. Attach additional signed and dated sheets, if necessary.					

2. ELIGIBILITY REQUIREMENTS

Average total number of employees	<input type="text"/>	This means the average number of employees for the preceding calendar year. An employee is typically any person for which the company issues a W-2, regardless of full-time, part-time or seasonal status or whether or not they have medical coverage.			
Average number of full-time equivalent employees	<input type="text"/>	For all employees included in the average total number of employees (above), calculate the average number of full-time equivalents for the preceding calendar year. The monthly full-time equivalents are calculated as follows: <ul style="list-style-type: none"> • number of full-time employees (who worked 30 hours or more per week on average); plus • total number of hours worked by part-time employees during the month capped at 120 hours, divided by 120. 			
Eligible employee count (including those employees who waive coverage):	Medical	Dental	Vision	Life	
Are you offering coverage to retirees (Non-Community Rated Medical, Dental and Vision)? <input type="checkbox"/> No <input type="checkbox"/> Yes					
Required age (minimum 50):		Minimum years of service:			
Number of retirees to be covered:	Medical:	Dental:	Vision:		
Does this company have any subsidiaries or affiliates, or are there any other associated entities that are eligible to file a federal or state combined tax return? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, enter information below:					
Company name				Total employees	
Probationary waiting period for eligible employees: <input type="checkbox"/> 0 days <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days <input type="checkbox"/> Other: _____ If you prefer months, please select “Other” and specify the number of months. Medical probationary waiting period must not exceed 90 days. HMO plans requiring referrals must not exceed 60 days.					
Employee effective provision (the employee termination date coincides with the effective date provision): <input type="checkbox"/> First of the month following probationary waiting period (required for HMO plans requiring referrals) <input type="checkbox"/> Immediately following probationary waiting period (required for 90 day probationary waiting period)					

Do you want to exclude a class of employees? No Yes
 If yes, check class to exclude:
 Union Non-union Hourly Salary Management Non-management Other:

Is this a Collectively Bargained Plan? No Yes Name of plan _____
 Plan number (assigned by employer for use in filing IRS form 5500): _____

Has this group been insured by Humana within the last three years? No Yes
 If yes, provide prior group number: _____ Termination date: _____

Do you wish to offer Domestic Partner coverage? No Yes

3. COBRA/STATE CONTINUATION

Is your group subject to: COBRA No Yes State Continuation No Yes

Are any present or former employees/dependent currently on or eligible to elect COBRA/State Continuation? No Yes
 If yes, enter information below. Attach additional signed and dated sheets (reorder GA-52660), if necessary.

Name of applicant	Qualifying event (e.g. termination of employment, divorce, etc)	Indicate if the applicant is currently on COBRA or State Continuation	COBRA/State Continuation			Lines of coverage (select all that apply)		
			Qualifying event date	Start date	End date	Medical	Dental	Vision
		<input type="checkbox"/> COBRA <input type="checkbox"/> State Continuation				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/> COBRA <input type="checkbox"/> State Continuation				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/> COBRA <input type="checkbox"/> State Continuation				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/> COBRA <input type="checkbox"/> State Continuation				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Plan Selection – Please review the Regulatory Pre-enrollment Disclosure Guide with your agent, broker or producer. Complete the quote number and reference number (if applicable) to indicate the plans elected.

4. MEDICAL PLAN SELECTION Electing Not electing

Sold quote number: _____

Plan 1 name _____ / Reference # _____

Plan 2 name _____ / Reference # _____

Plan 3 name _____ / Reference # _____

Plan 4 name _____ / Reference # _____

Attach additional signed and dated sheets (reorder GA-52659), if necessary.
 (For groups 100-299) Limited Bariatric Rider No Yes
 (For groups 300+) SAAOS Bariatric Rider No Yes

Do you offer a supplemental medical plan that partially or completely subsidizes any member cost-sharing including, but not limited to, deductible, coinsurance, or co-pays and/or have purchased or created a funding mechanism which will fund an Employee Spending Account at a level that exceeds 30% of the plan deductible? No Yes If yes, indicate amount funded \$ _____

EMPLOYER CONTRIBUTION (Percentage or dollar amount): Minimum employer contribution toward employee premium is [0]% or \$[0].
 Employee: _____ Employee/Spouse: _____ Employee/Child: _____ Family: _____

Participation – Available to employers with one or more enrolled employees and • Non-contributory - 100 % • Contributory - 25%	Number of employees waiving with other qualifying coverage:	Number of employees waiving without other qualifying coverage:	Number of employees enrolled:

Additional Product Selection (may not be available for all group sizes):
 Health Care Flexible Spending Account (FSA) Dependent Care Flexible Spending Account (FSD) Health Savings Account (HSA)
 Personal Care Account offered with plan specification:

5. HEALTH QUESTIONNAIRE (for Non-Community Rated groups):

1. Are there any disabled dependents over the age of 26 to be covered in this group? If yes, please provide on a separate sheet of paper (form# GA-52662): name of employee, dependent name, statement of disability/ diagnosis from attending physician, dependency statement from employee and the name of the current group carrier insuring the dependent.	<input type="checkbox"/> No <input type="checkbox"/> Yes
2. Has any employee been unable to work 10 or more consecutive days in the past 12 months due to an illness or injury?	<input type="checkbox"/> No <input type="checkbox"/> Yes
3. Is any employee presently not performing his or her duties on a full-time basis due to an illness or injury?	<input type="checkbox"/> No <input type="checkbox"/> Yes
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: <ul style="list-style-type: none"> • confined at home, in a hospital or in a treatment facility • who incurred more than \$25,000 of medical expenses in the past 12 months • who has been advised within the last 90 days to have surgery or be hospitalized • who is eligible for and/or covered by Medicare related to a disability or End-Stage Renal Disease 	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes
5. 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:	
AIDS or an AIDS-related complex	<input type="checkbox"/> No <input type="checkbox"/> Yes
Diabetes or any disease or disorder of the kidneys, liver or lungs	<input type="checkbox"/> No <input type="checkbox"/> Yes
Coronary artery disease, chest pain, heart surgery, or any disease of the arteries, or blood disorders; hemophilia	<input type="checkbox"/> No <input type="checkbox"/> Yes
Systemic disease including, but not limited to Lupus, Multiple Sclerosis or Multiple Dystrophy	<input type="checkbox"/> No <input type="checkbox"/> Yes
Stroke; Transient Ischemic Attack (TIA)	<input type="checkbox"/> No <input type="checkbox"/> Yes
Alcohol or drug abuse or dependence, or psychological disorder	<input type="checkbox"/> No <input type="checkbox"/> Yes
Cancer, and/or cancerous tumor; including skin cancer	<input type="checkbox"/> No <input type="checkbox"/> Yes
Organ transplant (other than corneal)	<input type="checkbox"/> No <input type="checkbox"/> Yes
Stomach, gall bladder, digestive, intestinal, or colon disorders	<input type="checkbox"/> No <input type="checkbox"/> Yes
6. Does your company currently sponsor short or long term disability? If yes, are any employees currently receiving benefits? Please indicate:	<input type="checkbox"/> No <input type="checkbox"/> Yes

If you answered yes to questions 2-5 above, please indicate the question number and explanation. Attach additional signed and dated sheets (GA-52661), if necessary.

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 R=Retiree

6. DENTAL PLAN SELECTION Electing Not electing

Sold quote number: _____

Plan 1 name _____ / Reference # _____

Plan 2 name _____ / Reference # _____

Plan 3 name _____ / Reference # _____

Attach additional signed and dated sheets (reorder GA-52659), if necessary.

EMPLOYER CONTRIBUTION (Percentage or dollar amount): Minimum employer contribution toward employee premium is [0]% or \$[0].

Employee: _____ Employee/Spouse: _____ Employee/Child: _____ Family: _____

Participation - Available to employers with one or more enrolled employees and <ul style="list-style-type: none"> • Non-Contributory plan - 100% • Contributory plan - 50% • Voluntary plan - minimum of 2 enrolled 	Number of employees waiving with other qualifying coverage:	Number of employees waiving without other qualifying coverage:	Number of employees enrolled:

CURRENT CARRIER

Is this group transferring group dental coverage from another group carrier? No Yes

Does prior coverage include orthodontia? No Yes

If yes, provide carrier name: _____ Proposed termination date: _____

7. VISION PLAN SELECTION Electing Not electing

Sold quote number: _____

Plan 1 name _____ / Reference # _____

Plan 2 name _____ / Reference # _____

Dual choice arrangements are subject to underwriting review.

EMPLOYER CONTRIBUTION (Percentage or dollar amount): Minimum employer contribution toward employee premium is [0]% or \$[0].

Employee: _____ Employee/Spouse: _____ Employee/Child: _____ Family: _____

Participation - Available to employers with: • one or more enrolled employees when sold with medical and/or dental; • five or more enrolled when standalone; and • Non-Contributory plan - 100% • Contributory plan - 50% • Voluntary plan - minimum of 5 enrolled	Number of employees waiving with other qualifying coverage:	Number of employees waiving without other qualifying coverage:	Number of employees enrolled:

8. LIFE PLAN SELECTION

Sold quote number: _____ Reference # _____

Basic Life and Accidental Death and Dismemberment - Electing Not electing

Participation Requirement - Available to employers with two or more enrolled employees.
 • Non-contributory plan - 100% • Contributory plan - 50%

Rate Guarantee: 2 Year 3 Year

Age Reduction Schedule: Schedule 1 Schedule 2 Schedule 3

Flat amount \$ _____

Salary plan - options are 1x to 7x salary (in .5 increments), rounded to the next highest \$1,000
 Salary level: ____ x salary Maximum benefit: \$ _____

Class schedule - no more than 2.5x between classes and 10x between the lowest and highest class. Complete the table below.

Class	Description	Flat amount or Salary level
1		
2		
3		
4		

Basic Dependent Life: Electing Not electing
 If yes, indicate volume amount \$20,000/ \$5,000 \$10,000/ \$2,500 \$5,000/\$1,000

Voluntary Employee Life: Available to employers with five or more or 25% of the eligible employees enrolled, whichever is greater.
 Electing Not electing Reference # _____

Do you want AD&D? <input type="checkbox"/> No <input type="checkbox"/> Yes Rate Guarantee: <input type="checkbox"/> 2 Year <input type="checkbox"/> 3 Year Age Reduction Schedule: <input type="checkbox"/> Schedule 1 <input type="checkbox"/> Schedule 2 <input type="checkbox"/> Schedule 3 (Basic and Voluntary Age Reduction Schedules must match) <input type="checkbox"/> Minimum amount \$ _____ <input type="checkbox"/> Maximum benefit \$ _____	Voluntary Dependent Life (only available if Employee Voluntary Life is elected) <input type="checkbox"/> No <input type="checkbox"/> Yes	Dependent Child Voluntary Amount <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000
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EMPLOYER CONTRIBUTION (Percentage or dollar amount) for **BASIC** Employee and Dependent Life **ONLY**: Minimum employer contribution toward employee premium is 100%..

Employee: _____ Employee/Spouse: _____ Employee/Child: _____ Family: _____

Number of hours worked per week to be eligible (select between 20 and 40 hours): _____

CURRENT CARRIER
 Is this group transferring group life coverage from another group carrier?: No Yes
 If yes, provide carrier name: _____ Proposed termination date: _____

As of the date of this application, list any employees currently disabled and not actively at work (attach additional signed and dated pages, if necessary): _____

9. THE FOLLOWING APPLIES TO ALL GROUPS SUBJECT TO ERISA

As claims administrator with authority to make claim determinations as described in Section 503 of the Employee Retirement Income Security Act (ERISA), we make final 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. As claims administrator, we shall have full and exclusive discretionary authority to: 1) interpret Policy or Group Plan provisions; 2) make decisions regarding eligibility for coverage and benefits; and 3) resolve factual questions relating to coverage and benefits.

You, the participating employer, policyholder, contract holder, or Certificate sponsor, intend to establish, sponsor, plan sponsor and endorse an employee benefit plan which will be governed by ERISA. You are the ERISA plan administrator.

10. THE FOLLOWING APPLIES TO ALL GROUPS

The group is only eligible if a bona fide business entity exists.

If you fail to pay premium when due, coverage may be subject to termination as specified under the terms of the Policy. You understand and agree that your coverage is continued monthly 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. You will receive advance written notice.

You will provide information or records upon request that we determine are relevant to this Employer Group Application and group coverage for inspection by the Trustee, Administrator, us, or our representative. For you to remain eligible you must meet the eligibility, participation and contribution requirements for each respective coverage at all times.

We have the right to use information provided by you to determine whether this Employer Group Application will be accepted or declined and to establish appropriate premiums.

For Non-Community Rated medical groups, Humana reserves the right to recalculate the rates if final enrollment due to demographic changes which are due to age, sex, coverage type, geographic area, that, in the aggregate, would impact premium more than 5%. Humana reserves the right to recalculate the rates based on final enrollment/participation.

11. AGREEMENT AND SIGNATURE – Review your policy/certificate carefully

You, the authorized representative of the group named herein, understand, agree and represent: You have read this Employer Group Application and the information you provided is accurate and complete and can be substantiated by your records. You have received and reviewed the applicable regulatory information and the Humana issued proposal, and you referred to the proposal to select the benefit plan(s) applied for in this Employer Group Application and confirmed your selection from the Humana issued proposal before signing below. By executing this Employer Group Application, you agree to its terms and represent and warrant that you shall comply with the terms of the policy and all applicable law. An act of fraud or an intentional misrepresentation of a material fact may void or terminate an individual's or group's coverage as specified under the terms of the Policy or Certificate. We shall rely on your representations and any information submitted by you or on your behalf. Providing incomplete, inaccurate or untimely information may reduce an individual's or group's coverage or may increase past premium; however, all statements shall be deemed representations and not warranties. In addition, any person who knowingly presents false information in an application for insurance or life settlement contract is guilty of a crime and, upon conviction, may be subject to fines or confinement in prison, or both.

Coverage is not in effect unless and until you receive written notification from us. The Employer Group Application will form part of any contract or coverage issued. The original version of this Agreement is in the English language. If there are any discrepancies or conflicts between the English and any other version that has been translated into another language, the English version will control. Neither you nor the agent 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.

DO NOT CANCEL ANY CURRENT GROUP COVERAGE UNTIL YOU RECEIVE WRITTEN NOTICE FROM US THAT WE HAVE ISSUED COVERAGE.

Dated on: _____ (month, day, year) at _____ (city and state)

By _____
Group authorized representative (Printed name) (Signature) (Title)

12. AGENT INFORMATION

1. Agency of Record (for commissions and correspondence)	2. Agent/Agency of Record (for split commissions)
Name (print or type)	Name (print or type)
Tax ID/Social Security Number/Humana Agent Number	Tax ID/Social Security Number/Humana Agent Number
Commission split <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, percentage: _____ (equals 100%)	Commission split <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, percentage: _____ (equals 100%)
1. Writing Agent/Broker Producer	2. Agent/Agency of Record
Name (print or type)	Name (print or type)
Tax ID/Social Security Number/Humana Agent Number	Tax ID/Social Security Number/Humana Agent Number
Commission split <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, percentage: _____ (equals 100%)	Commission split <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, percentage: _____ (equals 100%)

General Agency (Complete only if agency involved in sale)

General agency information pertains to: <input type="checkbox"/> Agency of Record <input type="checkbox"/> Writing Agent	
Name (print or type)	Tax ID/Social Security Number/Humana Agent Number

As the Agent, I acknowledge that I am responsible to meet with the group submitting this Employer Group 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 group in the Regulatory Pre-enrollment Disclosure Guide or other plan literature.

Writing Agent signature: _____

Date: _____

Small Employer Participation Requirement for Medical Coverage Amendment

This Small Employer Participation Requirement for Medical Coverage Amendment (“Amendment”) is made part of your Employer Group Application. The effective date of this Amendment is the effective date of your Policy.

The Employer Group Application is amended with the addition of the following participation requirement:

If the group is a partnership as defined under state law, medical coverage is available if the group has at least one common law employee who will be enrolled in the medical coverage or one bona fide partner who provides services on behalf of the partnership who will be enrolled in the medical coverage.

If the group is not a partnership as defined under state law and the group is considered to be wholly owned by one individual or one individual and his or her spouse, medical coverage is available only if the group has at least one common law employee who is not the owner or a legally recognized spouse of the owner who will be enrolled in the medical coverage.

I, the authorized representative of the group, understand, agree and represent:

1. I have read this Amendment and the group satisfies the participation requirement stated above, which can be substantiated by the group’s records.
2. For the group to remain eligible for medical coverage, the group must satisfy the participation requirement stated above at all times. If at any time the group does not satisfy the participation requirement, Humana may terminate the group’s medical coverage.

Dated on: _____ (month, day, year) at _____ (city and state)

By _____ (Signature) _____ (Title)
Group authorized representative (Printed name)