

Employer Group Application (Medical, Dental, Vision - Small Group 1-100)



COLORADO

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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”.

Medical plans insured or administered by Humana Insurance Company. HMO plans offered or administered by Humana Health Plan, Inc. and insured or administered by Humana Insurance Company. Dental plans insured or administered by HumanaDental Insurance Company or Humana Insurance Company. Alpha Dental Plan is offered and administered by Beta Health Association, Inc. and administered by HumanaDental Insurance Company. 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		
	<input type="text"/>	<input type="text"/>	<input type="text"/>		
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	
<input type="text"/>				<input type="text"/>	
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? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, check class to exclude: <input type="checkbox"/> Union <input type="checkbox"/> Non-union <input type="checkbox"/> Hourly <input type="checkbox"/> Salary <input type="checkbox"/> Management <input type="checkbox"/> Non-management <input type="checkbox"/> 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 CO-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 CO-52659), if necessary.

A limited health benefit plan may impose a total annual benefit maximum on the plan or on specific benefits under the plan, and what those amounts are that once the enrollee reaches the maximum amount, the enrollee is responsible for paying out-of-pocket for any further costs during that year.

Enrollees participating in a limited health benefit plan must sign a Statement of Understanding (reorder CO-72019).

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	Number of employees waiving with other qualifying coverage:	Number of employees waiving without other qualifying coverage:	Number of employees enrolled:
• Non-contributory - 100 % • Contributory - 25%			

For groups with 1-100 employees:

Health Care Flexible Spending Account (FSA) Dependent Care Flexible Spending Account (FSD) Health Savings Account (HSA)
 Personal Care Account offered with plan specification:

** Spouse also includes partner of a civil union

5. 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 CO-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: _____

** Spouse also includes partner of a civil union

6. 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: <ul style="list-style-type: none"> • one or more enrolled employees when sold with medical and/or dental; • five or more enrolled when standalone; and <ul style="list-style-type: none"> • 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:

** Spouse also includes partner of a civil union

If electing Life, please complete form # CO-52657-SB-LIFE.

7. 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, 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, 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.

8. 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 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.

9. 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. **IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.**

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)

10. 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: _____

Employer Group Application (Life - Small Group 1-100)



COLORADO

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".

Life plans insured or administered by 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):	Life	
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.		
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		
Do you want to exclude a class of employees? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, check class to exclude: <input type="checkbox"/> Union <input type="checkbox"/> Non-union <input type="checkbox"/> Hourly <input type="checkbox"/> Salary <input type="checkbox"/> Management <input type="checkbox"/> Non-management <input type="checkbox"/> Other:		
Is this a Collectively Bargained Plan? <input type="checkbox"/> No <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, provide prior group number: _____ Termination date: _____		
Do you wish to offer Domestic Partner coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes		

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.

3. LIFE PLAN SELECTION

Sold quote number: _____ Reference # _____

Basic Life and AD&D - 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): _____

** Spouse also includes partner of a civil union

If electing Medical, Dental, Vision, please complete form # CO-52657-SB. If electing Short Term Disability or Long Term Disability, please complete form # CO-52659-KIC. If electing Workplace Voluntary Benefits, please complete form # CO-52658.

4. 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, 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, 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.

5. 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 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.

6. 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. **IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.**

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)

7. 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: _____