Employer Group Application

Humana®

ADDITIONAL PLAN SELECTION – Short-Term Disability and Long-Term Disability

Please complete this form and return with CO-52657 to elect additional plan options for the group. Humana.com

SHORT-TERM DISABILITY (STD) and LONG-TERM DISABILITY (LTD) ELIGIBILITY REQUIREMENTS (**only** complete if one or both of these plans is elected)

	STD	LTD
Number of eligible employees:		

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):

Effective dates for changes in amounts of coverage:	**Effective first day of month following change?**	**Other:**
Increases / decreases due to change in class	☐ Yes	☐
Increases / decreases requested by employee	☐ Yes	☐

☐ **Special requests**: Check box and attach signed, additional sheet or letter if custom dating, face amounts, etc. are desired.

W-2 services option (please choose one):

☐ Option 1: Withhold state and federal income taxes and the employee's portion of FICA. Prepare and file W-2 forms.
☐ Option 2: Withhold federal income taxes and the employee's portion of FICA. Applicant waives W-2 forms services.

A detailed description of the W-2 services elected by applicant pursuant to this application will be sent to the applicant via mail. Such services will be performed in accordance with the above election and established as standard procedures.

SHORT-TERM DISABILITY (STD) ☐ Electing ☐ Not electing (Attach additional signed and dated sheets, if necessary) Available to groups with less than 100 employees.

Sold quote number: _____

Class 1 Name _____ Plan Name _____ / Reference #_____

Class 2 Name _____ Plan Name _____ / Reference #_____

Class 3 Name _____ Plan Name _____ / Reference #_____

Class 4 Name _____ Plan Name _____ / Reference #_____

EMPLOYER CONTRIBUTION (Percentage or dollar amount): _____
Are employer contributions taxed in employee's paycheck? ☐ Yes ☐ No

Number of hours worked per week to be eligible (select between 30 and 40 hours):

CURRENT CARRIER
Is this group transferring group disability coverage from another group carrier? ☐ Yes ☐ No

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

LONG-TERM DISABILITY (LTD) ☐ Electing ☐ Not electing (Attach additional signed and dated sheets, if necessary) Available to groups with less than 100 employees.

Sold quote number: _____
Class 1 Name _____ Plan Name _____ / Reference #_____
Class 2 Name _____ Plan Name _____ / Reference #_____
Class 3 Name _____ Plan Name _____ / Reference #_____
Class 4 Name _____ Plan Name _____ / Reference #_____
EMPLOYER CONTRIBUTION (Percentage or dollar amount): _____ Are employer contributions taxed in employee's paycheck? ☐ Yes ☐ No
Number of hours worked per week to be eligible (select between 30 and 40 hours):
CURRENT CARRIER Is this group transferring group disability coverage from another group carrier? ☐ Yes ☐ No If yes, provide carrier name: _____ Proposed termination date:_____

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

Short Term Disability and Long Term Disability Plans insured or administered by Kanawha Insurance Company.