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

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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".
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? ☐ No ☐ Yes
If yes, please explain. Attach additional signed and dated sheets, if necessary.

2. ELIGIBILITY REQUIREMENTS

Average total number of employees ☐	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 ☐	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: • 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? ☐ No ☐ Yes If yes, enter information below:

Company name	**Total employees**

Probationary waiting period for eligible employees: ☐ 0 days ☐ 30 days ☐ 60 days ☐ 90 days ☐ 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):
☐ First of the month following probationary waiting period (required for HMO plans requiring referrals)
☐ Immediately following 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

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? ☐ No ☐ Yes Rate Guarantee: ☐ 2 Year ☐ 3 Year Age Reduction Schedule: ☐ Schedule 1 ☐ Schedule 2 ☐ Schedule 3 (Basic and Voluntary Age Reduction Schedules must match) ☐ Minimum amount $_____ ☐ Maximum benefit $_____	**Voluntary Dependent Life** (only available if Employee Voluntary Life is elected) ☐ No ☐ Yes	**Dependent Child Voluntary Amount** ☐ $5,000 ☐ $10,000

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 ☐ No ☐ Yes If yes, percentage: _____ (equals 100%)	Commission split ☐ No ☐ 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 ☐ No ☐ Yes If yes, percentage: _____ (equals 100%)	Commission split ☐ No ☐ Yes If yes, percentage: _____ (equals 100%)

General Agency (Complete only if agency involved in sale)

General agency information pertains to: ☐ Agency of Record ☐ Writing Agent	
Name (print or type) CENTERSTONE dba BENEFITMALL	Tax ID/Social Security Number/Humana Agent Number 95-4018229

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: _____