1-99 Employer Group Application - COLORADO

HUMANA

FOR GROUP COVERAGE (1-99 ELIGIBLE EMPLOYEES) Humana.com or HumanaSpecialtyBenefits.com

Medical and Life plans insured or administered by Humana Insurance Company. HMO plans offered or administered by Humana Health Plan, Inc. or 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. Dental Discount Plans administered by CompBenefits Direct, Inc. Alpha Dental Plan insured and administered by Beta Health Association, Inc. Vision plans insured or administered by CompBenefits Insurance Company or HumanaDental Insurance Company or Humana Insurance Company. Short Term Disability, Long Term Disability, Life and Workplace Voluntary plans insured by Kanawha Insurance Company.

1. EMPLOYER COMPANY INFORMATION: Please type or print clearly in black ink

Internal use only Group number:

Full legal business name				Requested effective date _ _ / _ _ / _ _ _ _
Corporate/Situs location street address (P.O. Box not allowed)	City	State CO	ZIP code	County
Billing address (N/A if same as street address)	City	State	ZIP code	County
Type of business ☐ Corporation ☐ Partnership ☐ Sole Proprietorship ☐ Other (explain) _____		Date company established		Federal Tax ID
Nature of business/SIC code	Business phone number ( )		Business fax number ( )	
Do you have more than one location? ☐ No ☐ Yes				
Benefit Administrator/Management contact name:				
Phone number ( )	Fax number ( )	E-mail		
Management contact: Mother's maiden name _____ (this will be used to gain access to the Employer Self-Service Center on www.Humana.com)				
Billing contact name:				
Phone number ( )	Fax number ( )	E-mail		
Are separate divisions/classes required for billing or reporting? ☐ No ☐ Yes If yes, please explain. If additional space is needed, please attach an additional page. Each additional page must be signed and dated.				

Also complete this section if you are selecting Workplace Voluntary Benefits

Is this group a government entity or a church? ☐ No ☐ Yes

Due date Effective date of policy and due date of first premium will be (month, day, year) _ _ / _ _ / _ _ _ _

Colorado State Notices

COLORADO INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY HEALTH BENEFIT PLAN IT MARKETS IN COLORADO TO SMALL EMPLOYERS OF 1-50 EMPLOYEES, INCLUDING BASIC OR STANDARD HEALTH BENEFIT PLAN, UPON THE REQUEST OF A SMALL EMPLOYER TO THE ENTIRE SMALL GROUP REGARDLESS OF THE HEALTH STATUS OF ANY INDIVIDUALS IN THE GROUP. BUSINESS GROUPS OF ONE CANNOT BE REJECTED UNDER A BASIC OR STANDARD HEALTH BENEFIT PLAN DURING OPEN ENROLLMENT PERIODS AS SPECIFIED BY LAW.

Colorado law 4-6-7 requires Humana Insurance Company to notify small employers with 10 or more eligible employees that they are entitled to a choice of composite rates for age banded rates and have the right to see what the premium would be if quoted either way. The total premium quoted will be the same when choosing age or composite rates. However, composite rates show average rates by coverage type and age rates show actual rate for each individual on the census.

2. ELIGIBILITY REQUIREMENTS

Number of employees on payroll _____. An employee who is eligible to apply for insurance is one who is actively at work on a full-time basis working at least the number of hours per week as indicated in the table below.

	All
A. Number of hours worked per week to be eligible (select between 20 and 40 hours)	
B. Number of employees in a probationary waiting period (do not include in the eligible count below in C)	
C. Total number of eligible employees	

Probationary waiting period for eligible employees: ☐ 0 days ☐ 30 days ☐ 60 days ☐ 90 days ☐ Other (specify) _____
(if you prefer months, please select "Other" and specify the number of months)

New/Rehire employee effective provision: (On all plans, except STD and LTD, the employee termination date coincides with the effective date provision.)
☐ First of month following probationary waiting period
☐ Immediately following probationary waiting period

Do you want to exclude a class of employees? ☐ No ☐ Yes
If yes, check class to exclude: (Options vary by plan. Refer to the Underwriting Requirements for each plan.)
☐ union ☐ non-union ☐ hourly ☐ salary ☐ management ☐ non-management ☐ Other: _____

Has this group been insured by Humana within the last three years? ☐ No ☐ Yes
If yes, please provide prior group number and termination date:

Is this a Collectively Bargained Plan? ☐ No ☐ Yes Name of Plan _____
Plan number _____ (Assigned by Employer for use in filing IRS form 5500)

Retiree information

For groups 26+, are you offering coverage to retirees? ☐ No ☐ Yes If yes, required age _____ Minimum years of service _____

	All	Medical	Dental	Vision	Life (if applicable)
Number of current retirees to be covered					

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

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)

Short Term Disability and Long Term Disability only

Effective dates for changes in amounts of coverage
Increases/decreases due to change in class: ☐ effective first day of month following date change ☐ Other _____
Increases/decreases requested by employee: ☐ effective first day of month following date requested ☐ Other _____
Increases (with Evidence of Insurability) requested by employee: ☐ effective first day of month following approval date ☐ Other _____
Decreases due to age: ☐ effective first day of month following age change ☐ Other _____

Evidence of Insurability required if amount of Basic plus Voluntary Life Insurance applied for exceeds amounts below:

	Class 1	Class 2
Employee Life	$	$
Spouse Life	$	$
Employee LTD	$	$

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

3. COBRA/STATE CONTINUATION

Is your group subject to: COBRA ☐ No ☐ Yes State Continuation ☐ No ☐ Yes				
Number of existing COBRA participants	Medical:	Dental:	Vision:	Supplemental Health:
How many in COBRA election period	Medical:	Dental:	Vision:	Supplemental Health:

Are any present or former employees/dependents currently on or eligible to elect COBRA/State Continuation? ☐ No ☐ Yes
If yes, enter information below. Attach additional signed and dated sheets (reorder GN-52247) if necessary.

Name of applicant	Qualifying event (e.g. termination of employment, divorce, etc.)	Qualifying event date	COBRA/State Continuation	
			Start date	End date

4. EMPLOYER CONTRIBUTION(S)

Coverage		Medical	Dental	Life	Vision	STD	LTD	Workplace Voluntary	Spending Account*
Employer's contribution for:	Employee	%	%	%	%	%	%	%	$
	Employee/spouse	%	%	%	%	N/A	N/A	%	$
	Employee/child	%	%	%	%	N/A	N/A	%	$
	Family	%	%	%	%	N/A	N/A	%	$

(Medical only) Do you as an employer currently fund any of the plan deductible for the employees? ☐ No ☐ Yes
If yes, indicate amount funded $_____

*For medical plans, Humana reserves the right to re-evaluate rates and require new premium prior to underwriting approval or issuing coverage with employer contributions greater than 50% of a plan's deductible to an employee's Spending Account.

5. PRIOR/CURRENT CARRIER INFORMATION

	Medical	Dental	Life	STD	LTD
Is this group transferring from another group carrier?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, provide carrier name					
Did prior dental coverage include orthodontia? If yes, submit most recent carrier billing with effective and termination dates.	N/A	☐ No ☐ Yes	N/A	N/A	N/A
Proposed termination date					

(Medical only) Do you as an employer currently fund any of the plan deductible for the employees? ☐ No ☐ Yes
If yes, indicate amount funded $_____

For Medical only employees Group's renewal date:

Current carrier rates	Employee $	Spouse $	Child(ren) $	Family $
Plan design		Office visit copay $	Per confinement copay $	
Coinsurance In %_____ Out %_____		Deductible In %_____ Out%_____	Out of pocket In %_____ Out %_____	
Emergency room copay $		Prescription drug benefit		
Renewal rates	Employee $	Spouse $	Child(ren) $	Family $

How many medical carriers have you had in the past five years?

For Workplace Voluntary Benefits

Existing coverage available to employees

Disability income carrier _____ ☐ Individual ☐ Group Coverage termination date _____

CI/Cancer carrier _____ ☐ Individual ☐ Group Coverage termination date _____

6. PRODUCT SELECTION - To complete this section, please refer to the Underwriting Requirements (reorder CO-52347) and your proposal. Also review the Regulatory Pre-enrollment Disclosure Guide with your Broker.

Workers' Compensation (applicable for Medical plans all group sizes)
Do you wish to have 24-hour coverage for employees not covered by Workers' Compensation? ☐ No ☐ Yes
If yes, name(s):

a. MEDICAL PLANS

	Plan 1	Plan 2	Plan 3
Plan name (as shown in your proposal)			
Office/Specialist copay (if applicable)	$ / $	$ / $	$ / $
Coinsurance	In % / Out %	In % / Out %	In % / Out %
Deductible	In $ / Out $	In $ / Out $	In $ / Out $
Out-of-pocket limit	In $ / Out $0	In $ / Out $0	In $ / Out $0
Prescription Drug/Retail Card (Level 1 / 2 / 3 / 4)	$ / $ / $ / %	$ / $ / $ / %	$ / $ / $ / %
Prescription Drug/Retail Card - RxImpact (Group A / B / C / D)	$ a/ $ a/ $ a/$ a	$ a/ $ a/ $ a/$ a	$ a/ $ a/ $ a/$ a
Network name			

Additional 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
Other:	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes

A limited health benefit plan may impose an 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).

State Plans for groups of 1-50 lives and a business group of one

Colorado Basic Limited Mandate Health Benefit Plan
• indemnity
• preferred provider organization (PPO)
Colorado Standard Health Benefit Plan
• indemnity
• preferred provider organization (PPO)
• Special state options
  • Colorado Alcoholism
  • Colorado mental disorder mandated benefit
	Colorado law allows small employers with 1-50 employees and business groups of one, who, since July 1, 1989, have either not provided group health insurance to their employees or have provided coverage from a licensed health insurance company that did not include mental health coverage may waive the Colorado mandated psychological/mental disorders benefits of this plan.
	○ I meet the above criteria and wish to waive the Colorado mandated mental disorders benefits of this plan. Please provide your current/prior health insurance company's address, phone number, and plan number below.

Current/Prior Health Insurance Company:	
Address:	
Phone number:	Plan number:

a. MEDICAL PLANS (continued)

Health Questionnaire for groups enrolling 1-99 employees: (check all that apply)

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 a treatment facility ☐ No ☐ Yes
   - who incurred more than $10,000 of medical expenses in the last 24 months ☐ No ☐ Yes
   - who has been advised within the last 90 days to have surgery or be hospitalized ☐ No ☐ 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 who received treatment, had treatment recommended, or had medication prescribed by a doctor, psychiatrist, psychologist or other licensed practitioner within the past 1-24 months for any of the following:

• AIDS or an AIDS-related complex or other immune system disorder	☐ No ☐ Yes	• Diabetes or any disease or disorder of the kidneys, liver or lungs	☐ No ☐ Yes
• Alcohol or drug abuse or dependence, or psychological disorder	☐ No ☐ Yes	• Systemic disease including, but not limited to Lupus, Multiple Sclerosis, or Muscular Dystrophy	☐ No ☐ Yes
• Cancer or cancerous tumor	☐ No ☐ Yes	• Heart or vascular disease or stroke	☐ No ☐ Yes
• Organ transplant (other than corneal)	☐ No ☐ Yes		

If you answered yes to questions 1-4 above, please indicate the question number and explanation. Attach additional signed and dated sheets (reorder GN-52334) 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/State Continuation R=Retiree Class

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.

b. DENTAL PLANS (all group sizes)

	Plan 1	Plan 2
Plan name (as shown on your proposal)		
Funding type	☐ Employee sponsored ☐ Voluntary	☐ Employee sponsored ☐ Voluntary
Coinsurance	In % / % / % Out % / % / %	In % / % / % Out % / % / %
Deductible	In $ Out $	In $ Out $
Annual Maximum	$_____	$_____
Preventive Services deductible options	☐ Apply deductible ☐ Waive deductible	☐ Apply deductible ☐ Waive deductible
Periodontic/Endodontic options	☐ Basic ☐ Major	☐ Basic ☐ Major
Composite Fillings for Molars	☐ No ☐ Yes	☐ No ☐ Yes
Implant Coverage	☐ No ☐ Yes	☐ No ☐ Yes
Orthodontia options	☐ Child only: Lifetime Ortho Max $_____ ☐ Adult & Child: Lifetime Ortho Max $_____	☐ Child only: Lifetime Ortho Max $_____ ☐ Adult & Child: Lifetime Ortho Max $_____
Out of network reimbursement options	☐ Max allowable fee ☐ In-network fee schedule	☐ Max allowable fee ☐ In-network fee schedule
Open Enrollment	☐ No ☐ Yes	

c. LIFE (**all group sizes)** - Please refer to your proposal

Basic Employee Life and AD&D (AD&D only applicable to certain plans)

☐ Flat amount -- indicate level: $_____ Increment (if applicable) $_____

☐ Salary plan -- options are 1x to 6x salary, rounded to the next highest $1,000. Indicate salary level: $_____x salary

☐ Class schedule -- no more than 2.5 times between the classes and 10 times between the lowest and highest class (complete table below).

Class	Description	Benefit Amount / Salary Factor
I		
II		
III		
IV		

Basic Dependent Life ☐ No ☐ Yes If yes, indicate volume amount $_____

Voluntary Life

Voluntary Employee Life ☐ No ☐ Yes If yes, do you want to select AD&D? ☐ No ☐ Yes

Voluntary Dependent Life (Available only when enrolled in Voluntary Life) ☐ No ☐ Yes

Portability of coverage (Applicable to Voluntary Life only) Groups 1-99 included

d. VISION PLANS **(all group sizes)**

Plan name (as shown on your proposal)

STD/LTD FOR GROUP SIZES 10+ ONLY

ELIGIBILITY REQUIREMENTS/EMPLOYER CONTRIBUTIONS (All classes)

Effective dates for changes in amounts of coverage

Evidence of Insurability required if amount of coverage applied for exceeds amounts for Employee STD Class 1 $_____ Class 2 $_____

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.

Is Employer Contribution Taxed in Employee's Paycheck? ☐ No ☐ Yes

EMPLOYER COMPANY INFORMATION CONTRIBUTIONS (100+ONLY)

Type of Billing: ☐ Self Billed ☐ Listed Billed **Premium mode:** ☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual

Coverage: Employer's contribution for Employee Buy Up STD_____% Buy Up STD_____%

e. SHORT TERM DISABILITY (group sizes 10+). Attach additional signed and dated sheets (reorder GN-52336) if necessary.

Name of Class 1	
Funding type	☐ Contributory ☐ Non-contributory ☐ Voluntary
Benefit schedule (select one)	☐ 50% ☐ 60% ☐ 66.67% ☐ Other _____ ☐ Flat Amount $ _____ (**100+only)** ☐ Incremental amount $_____
Weekly Benefit Minimum	**(10-99)** $25.00 **(100+only)** $_____
Weekly Benefit Maximum	$_____
Earnings Definition	**(10-99)** ■ Base Salary **(100+only)** ☐ Base Salary ☐ Average _____ months bonus ☐ Average _____ months commission ☐ Other _____
Duration Weeks	Weeks: ☐ 13 ☐ 26 ☐ 52 ☐ Other _____
Elimination period (Accident/Sickness)	☐ 1/8 ☐ 8/8 ☐ 15/15 ☐ 30/30 ☐ Other _____
Pre-existing limitation	**(2-99)** ☐ None ☐ 3/12 ☐ 6/12 ☐ Other _____ **100+ only)** ☐ None ☐ 3/3/12 ☐ Other _____
Waiting period: Current employees	☐ Eligible on date of employment ☐ Eligible after active employment for _____ days
Waiting period: Rehired/New employees	☐ Eligible on date of employment ☐ Eligible after active employment for _____ days
Rate Guarantee	☐ 1 Year ☐ 2 Years ☐ Other _____

Name of Class 2	
Funding type	☐ Contributory ☐ Non-contributory ☐ Voluntary
Benefit schedule (select one)	☐ 50% ☐ 60% ☐ 66.67% ☐ Other _____ ☐ Flat Amount $ _____ (**100+only)** ☐ Incremental amount $_____
Weekly Benefit Minimum	**(10-99)** $25.00 **(100+only)** $_____
Weekly Benefit Maximum	$_____
Earnings Definition	**(10-99)** ■ Base Salary **(100+only)** ☐ Base Salary☐ Average _____ months bonus ☐ Average _____ months commission ☐ Other _____
Duration Weeks	Weeks: ☐ 13 ☐ 26 ☐ 52 ☐ Other _____
Elimination period (Accident/Sickness)	☐ 1/8 ☐ 8/8 ☐ 15/15 ☐ 30/30 ☐ Other _____
Pre-existing limitation	**(2-99)** ☐ None ☐ 3/12 ☐ 6/12 ☐ Other _____ **(100+ only)** ☐ None ☐ 3/3/12 ☐ Other _____
Waiting period: Current employees	☐ Eligible on date of employment ☐ Eligible after active employment for _____ days
Waiting period: Rehired /New employees	☐ Eligible on date of employment ☐ Eligible after active employment for _____ days
Rate Guarantee	☐ 1 Year ☐ 2 Years ☐ Other _____

f. LONG TERM DISABILITY (group sizes 10+). Attach additional signed and dated sheets (reorder GN-52336) if necessary.

Name of Class 1	
Funding type	☐ Contributory ☐ Non-contributory ☐ Voluntary
Benefit schedule (select one)	☐ 50% ☐ 60% ☐ 66.67% ☐ Other _____ (100+only) ☐ Incremental amount $_____
Monthly Benefit Minimum	**(2-99)** ■ Greater of $100 or 10% of Monthly Income Loss **(100+only)** ☐ $100 or 10% monthly salary ☐ Other _____
Monthly Benefit Maximum	$_____
Earnings Definition	**(2-99)** ■ Base Salary **(100+only)** ☐ Base Salary ☐ Average _____ months bonus ☐ Average _____ months commission ☐ Other _____
Duration	☐ 2 Years ☐ 5 Years ☐ SSNRA ☐ Other _____
Elimination period	Days: ☐ 30 ☐ 60 ☐ 90 ☐ 180 ☐ Other _____
Definition of disability	Year own occupation: ☐ 2 ☐ 3 ☐ to age 65 ☐ Other _____
Pre-existing limitation	**(2-99)** ☐ 3/3/12 ☐ 3/6/12 ☐ 6/6/12 ☐ 6/6/24 ☐ 12/12/24 ☐ Other _____ **(100+ only)** ☐ 3/3/12 ☐ 6/6/12 ☐ 3/12 ☐ 6/12 ☐ Other _____
Mental health and substance abuse limitation	☐ 24 month Outpatient ☐ 12 month Outpatient ☐ Other _____
Waiting period: Current employees	☐ Eligible on date of employment ☐ Eligible after active employment for _____ days
Waiting period: Rehired /New employees	☐ Eligible on date of employment ☐ Eligible after active employment for _____ days
Rate Guarantee	☐ 1 Year ☐ 2 Years ☐ Other _____

Name of Class 2	
Funding type	☐ Contributory ☐ Non-contributory ☐ Voluntary
Benefit schedule (select one)	☐ 50% ☐ 60% ☐ 66.67% ☐ Other _____ (100+only) ☐ Incremental amount $_____
Monthly Benefit Minimum	**(2-99)** ■ Greater of $100 or 10% of Monthly Income Loss **(100+only)** ☐ $100 or 10% monthly salary ☐ Other _____
Monthly Benefit Maximum	$_____
Earnings Definition	**(2-99)** ■ Base Salary **(100+only)** ☐ Base Salary ☐ Average _____ months bonus ☐ Average _____ months commission ☐ Other _____
Duration	☐ 2 Years ☐ 5 Years ☐ SSNRA ☐ Other _____
Elimination period	Days: ☐ 30 ☐ 60 ☐ 90 ☐ 180 ☐ Other _____
Definition of disability	Year own occupation: ☐ 2 ☐ 3 ☐ to age 65 ☐ Other _____
Pre-existing limitation	**(2-99)** ☐ 3/3/12 ☐ 3/6/12 ☐ 6/6/12 ☐ 6/6/24 ☐ 12/12/24 ☐ Other _____ **(100+ only)** ☐ 3/3/12 ☐ 6/6/12 ☐ 3/12 ☐ 6/12 ☐ Other _____
Mental health and substance abuse limitation	☐ 24 month Outpatient ☐ 12 month Outpatient ☐ Other _____
Waiting period: Current employees	☐ Eligible on date of employment ☐ Eligible after active employment for _____ days
Waiting period: Rehired /New employees	☐ Eligible on date of employment ☐ Eligible after active employment for _____ days
Rate Guarantee	☐ 1 Year ☐ 2 Years ☐ Other _____

Additional benefits: Please refer to your proposal for additional benefits availability with plan selected. Attach additional signed and dated sheets (form GN-52336) if necessary.

Cost of living adjustment (3%)	**(2-99)** ☐ No ☐ Yes If Yes, ■ Lesser of 3% or 1/2 CPI Select Number of Adjustments ☐ 5 ☐ 10 **(100+only)** ☐ No ☐ Yes If Yes, select, ☐ Lesser of 3% or 1/2 CPI ☐ Lesser of 6% or 1/2 CPI Number of Adjustments ☐ 5 ☐ 10
Activities of Daily Living	☐ No ☐ Yes If Yes, select additional Maximum Amount: ☐ 10% ☐ 20% ☐ 30% ☐ 40%
Business Income Protection	**(2-99)** ☐ No ☐ Yes If Yes, ■ 25% to $5,000 **(100+only)** ☐ No ☐ Yes If Yes, select: ☐ 15% to $2,500 ☐ 25% to $2,500
Special Conditions Limitation	**(2-99)** ☐ No ☐ Yes If Yes, ■ 24 months **(100+only)** ☐ No ☐ Yes If Yes, select: ☐ None ☐ 12 months ☐ 24 months
Survivor Income Benefit	**(2-99)** ☐ 3 month gross lump sum ☐ 6 month gross lump sum **(100+only)** ☐ No ☐ Yes If Yes, ☐ 3 month gross lump sum ☐ 6 month gross lump sum
Infectious & Contagious Disease **(100+only)**	☐ No ☐ Yes If Yes, select: Waiting Period: ☐ 6 months ☐ 12 months Earnings Loss: ☐ 20% ☐ 40% Duration of Benefits: ☐ 2 Years ☐ 3 Years ☐ 4 Years ☐ Duration of Claim Benefits Cease if Earnings Exceed: ☐ 80% ☐ 60%
Accidental Dismemberment and Loss of Sight **(100+only)**	☐ No ☐ Yes If Yes, select: Loss Occurs within: ☐ 90 Days ☐ 180 Days ☐ 365 Days
Extended Earnings **(100+only)**	☐ No ☐ Yes If Yes, select: Qualification of Benefit: ☐ Less than 60% of PDE ☐ Less than 80% of PDE ☐ Less than 100% of PDE Benefit End Date: The Lesser of ☐ 12 ☐ 24 ☐ 6 ☐ 3 months or when Earnings Exceed Qualification %
Pension Contribution **(100+only)**	☐ No ☐ Yes
Medical Premium Supplemental **(100+only)**	☐ No ☐ Yes If Yes, select: Duration of Benefits: ☐ 2 Years ☐ 3 Years ☐ 4 Years ☐ 5 Years ☐ Duration of Claim

h. WORKPLACE VOLUNTARY (all group sizes)

DISABILITY INCOME PLUS ☐ No ☐ Yes

Plan design ☐ Benefits are provided in conjunction with a HSA plan
☐ Benefits will be offered in conjunction with an IRS-qualified pre-tax plan

Benefit period (select all that apply) ☐ 3 Months ☐ 6 Months ☐ 1 Year ☐ 2 Years ☐ 3 Years

Elimination period (select all that apply) ☐ 0/7 ☐ 7/7 ☐ 0/14 ☐ 14/14 ☐ 30/30 ☐ 60/60
☐ 90/90 ☐ 180/180 ☐ 365/365

Optional benefits - Employer selectable ☐ Loss of Work ☐ 24 Hour Coverage Rider ☐ Takeover benefit
☐ Mental, Nervous, Alcohol and Drug Abuse Rider ☐ No ☐ Yes
☐ Sickness Elimination Period Waiver (Available only if 7 or 14 day Elimination Period is selected for Sickness)

Optional benefits - Employee selectable ☐ COBRA benefit ☐ Physical Therapy benefit ☐ ICU/CCU

☐ Disability Income Advantage ☐ 3 Months ☐ 6 Months ☐ 1 Year ☐ 2 Years ☐ 3 Years

Base Benefit Period (select all that apply) ☐ 0/7 ☐ 7/7 ☐ 0/14 ☐ 14/14 ☐ 30/30
☐ 90/90 ☐ 180/180 ☐ 365/365

Optional Riders ☐ 24-hour Coverage ☐ Hospital Confinement Rider ☐ Takeover
☐ COBRA Rider ☐ Limited Mental Health/Emotional Disease (only available with EP 0/14, 14/14, or 30/30)

ACCIDENT ☐ Group ☐ Trust ☐ Individual

Optional Benefits (May not be available with all plans)
☐ Hospital Intensive Care (per day)
☐ Fracture and Dislocation
☐ Accident Total Disability (Elimination period)
☐ On-the-Job Coverage

Base Plan ☐ Level 1 ☐ Level 2 ☐ Level 3 ☐ Level 4
☐ $150 ☐ $300 ☐ $450 ☐ $600
☐ $750 ☐ $1,500
☐ 1 Day ☐ 7 Days ☐ 14 Days ☐ 30 Days

h. WORKPLACE VOLUNTARY (all group sizes) (continued)

CRITICAL ILLNESS ☐ No ☐ Yes	**Plan design**	☐ Benefits are provided in conjunction with a HSA plan ☐ Benefits will be offered in conjunction with an IRS-qualified pre-tax plan
Coverage choices	☐ Vascular ☐ Cancer	☐ Other critical illnesses 100% of face amount
Optional benefits - Employer selectable	☐ Benefit Recurrence ☐ Loss of Work	☐ Takeover benefit
Optional benefits - Employee selectable	☐ Health Screening benefit $_____	☐ Automatic Benefit insurance
CRITICAL LIFE ☐ No ☐ Yes	**Plan design** ☐ 10 Year ☐ 20 Year	
Optional benefits - Employer selectable	☐ Waiver of Premium ☐ Loss of Work ☐ Takeover benefit ☐ Additional Benefit Increase ☐ Accelerated Living benefit - Critical illness _____% ☐ Accidental Death and Loss of Sight Dismemberment	
CANCER ☐ Cancer Expense ☐ Group Lump Sum Cancer ☐ Cancer Lump Sum 10-50		
Optional Riders - Cancer Expense	☐ Hospital Indemnity ☐ Lump sum First Diagnosis	
Optional Riders - Cancer Lump Sum 10-50	☐ Lifetime Pay ☐ 20 Pay ☐ Return of Premium	
Optional benefits - Group Lump Sum Cancer Employer selectable	☐ Benefit Recurrence ☐ Loss of Work ☐ Takeover benefit	
Optional benefits - Group Lump Sum Cancer Employee selectable	☐ Health Screening benefit $_____ ☐ Automatic Benefit Increase	
WHOLE LIFE ☐ Whole Life 65 ☐ Whole Life 90 ☐ Whole Life 99		
Optional Riders	☐ Waiver of Premium ☐ AD&D ☐ Loss of work ☐ Automatic Benefit Increase ☐ Family Term ☐ Employee Term to Age 65	

SUPPLEMENTAL HEALTH ☐ No ☐ Yes **Base plan**	☐ Plan A	☐ Plan B	☐ Plan C	☐ Plan D
Hospital Indemnity	$100/day	$200/day	$300/day	$500/day
Hospital First Occurrence	$250/day	$500/day	$500/day (days 1-2), $750/day (days 3-4)	$500/day (days 1-2), $1,000/day (days 3-4)
Optional benefits - Employer selectable				
☐ Emergency Room	$50/day (ER), $40/ day (urgent care)	$100/day (ER), $80/ day (urgent care)	$150/day (ER), $120/ day (urgent care)	$250/day (ER), $200/ day (urgent care)
☐ ICU/CCU/Burn Unit benefit	$100/day	$200/day	$600/day	$1,000/day
☐ Surgical Schedule	$500	$1,000	$1,000	$2,000
☐ Diagnostic, Laboratory and X-ray	$25/test (hospital), $20/test (doctor's office or clinic)	$25/test (hospital), $20/test (doctor's office or clinic)	$50/test (hospital), $40/test (doctor's office or clinic)	$75/test (hospital), $60/test (doctor's office or clinic)
☐ Outpatient Office Visit	$25	$50	$75	$100
☐ Wellness	$50	$50	$100	$150

If multiple plans are selected and plan availability is limited by class, please list what class of employees are eligible for each plan.

7. THE FOLLOWING APPLIES TO ALL COMPANIES AND PLANS EXCEPT WORKPLACE VOLUNTARY

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 Certificate 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.

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. Affiliated or subsidiary companies that are eligible to file a combined tax return are considered one employer.

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 with authority to make claim determinations as described in Section 503 of ERISA, we make final decisions under the Policy or Certificate 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 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 or Certificate. Except for non-payment of premium or when a group or individual is not or has not been eligible for coverage, you will be provided with a 30 day advance written notice, unless a greater period is expressly specified in the Policy. 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. Changes to premium rate for short term disability plans may differ if you have agreed to participate in a Rate Guarantee program. You will receive advance written notice.

For you to remain eligible for the Policy or Certificate, the eligibility, underwriting and participation requirements must be maintained, for each respective coverage. Failure to maintain the plan eligibility, underwriting and participation requirements will terminate your coverage under the Policy or Certificate. Other termination provisions are stated in the Policy or Certificate.

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 unless permitted by law.

8. AGREEMENT AND SIGNATURE - Review your policy/certificate carefully

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 belief 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. Unless we are informed differently, we will perform a one-time electronic check conversion of the first month's premium payment from the account and for the amount designated on the binder check. 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 are met. Only individuals who meet the eligibility requirements of the plan are eligible to maintain coverage. Providing incomplete, inaccurate, or untimely information may void, reduce, or increase past premium, or terminate an individual's coverage or the 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.This document will form part of any contract or coverage issued. Coverage is not in effect unless and until you receive written notification from us. If this application is declined, we will return the premium deposit submitted with this application. 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.

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.

8. AGREEMENT AND SIGNATURE - Review your policy/certificate carefully (continued)

If you decide not to sign this agreement, we will decline to enroll you in an insurance product or to give you insurance benefits.

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

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

By: _____ _____ _____
(Employer printed name) (Employer signature) (Title)

For Workplace Voluntary Benefits - only necessary for non-employer groups.

By: _____ _____ _____
(Plan sponsor printed name) (Plan sponsor signature) (Title)

9. AGENT/PRODUCER 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: (total should equal 100%)	Commission split ☐ No ☐ Yes If yes, percentage: (total should equal 100%)
1. Writing Agent (Producer)	**2. Writing Agent (Producer)**
Name (print or type)	Name (print or type)
Social Security Number/Humana Agent Number	Social Security Number/Humana Agent Number
Commission split ☐ No ☐ Yes If yes, percentage: (total should equal 100%)	Commission split ☐ No ☐ Yes If yes, percentage: (total should equal 100%)

General Agency (Complete only if agency involved in sale)			
General agency information pertains to: ☐ Agency of Record ☐ Writing Agent			
Name (print or type)	Tax ID/Humana Agent Number		
Address	City	State	ZIP code

As the Writing Agent/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, or one of its subsidiaries. These provisions are available to me and the employer in the Regulatory Pre-enrollment Disclosure Guide or other plan literature.

Writing Agent's Signature: _____ Date: _____

Disclaimer: Beta Health Association, Inc. and HumanaDental Insurance Company are parties to a marketing and administrative service relationship. Beta Health Association, Inc. is responsible for paying claims for benefits and determining eligibility for coverage under the policy or group plan insured or administered by Beta Health Association.