

Employer Group Application

TEXAS
 HUMANA / HUMANADENTAL / COMPBENEFITS

You have the option to choose this Consumer Choice of Benefits Health Insurance Plan that, either in whole or in part, does not provide state-mandated health benefits normally required in accident and sickness insurance policies in Texas. This standard health benefit plan may provide a more affordable health insurance policy for you although, at the same time, it may provide you with fewer health benefits than those normally included as state-mandated health benefits in policies in Texas. If you choose this standard health benefit plan, please consult with your insurance agent to discover which state-mandated health benefits are excluded in this policy.

Please refer to your proposal to complete this application. This document will form part of any contract issued. Print clearly in black ink, and answer all questions or indicate "not applicable".

Your Business Profile

Business name		Federal tax ID number	
Location address (not a P.O. Box)			
City	State	Zip code	County
Do you have more than one location? <input type="radio"/> No <input type="radio"/> Yes			
Billing address (if different)			
City	State	Zip code	County
Nature of business or SIC number		Date company established	
Business status: <input type="radio"/> Corporation <input type="radio"/> Partnership <input type="radio"/> Sole Proprietorship <input type="radio"/> Other: (explain)			
Business phone number		Fax number	
Management contact		Administrative contact	
Management contact e-mail address			
Management contact: Mother's maiden name _____ <i>This will be used to gain access to the Employer Self-Service Center on www.Humana.com.</i>			

All Certificate(s) of Insurance/Evidence(s) of coverage are available to you and your employees on our Web site, www.humana.com. If you would also like to receive a paper copy of this information, you must fill in the circle below.

I wish to receive paper copies of Certificate(s) of Insurance/Evidence(s) of Coverage.

General Eligibility

Requested effective date	How many employees are on your payroll?
How many hours per week must your employees usually work to be eligible? (select between 20 and 30 hours)	
For groups of 51-99: Do you want to exclude a class of employees? <input type="radio"/> No <input type="radio"/> Yes	
If yes, check class to exclude: (Options may not be available for all plans. Refer to the Underwriting Requirements for each plan.)	
<input type="radio"/> union <input type="radio"/> non union <input type="radio"/> hourly <input type="radio"/> salary <input type="radio"/> management <input type="radio"/> non-management	
How long must employees wait after hire date to become eligible? <input type="radio"/> 0 days <input type="radio"/> 30 days <input type="radio"/> 60 days	
<input type="radio"/> 90 days (groups of 2-50 may not exceed 90 days) <input type="radio"/> Other, specify:	
How many employees are eligible for coverage?	
New employee effective date provision: <input type="radio"/> First of month following waiting period (required for HMO, POS and DHMO plans)	
<input type="radio"/> Immediately following waiting period	
On all plans, the employee termination date coincides with the effective date provision.	
When offering multiple choice plans, the waiting period and effective date must be the same on all plans.	
Is this employer required to comply with COBRA regulation? <input type="radio"/> No <input type="radio"/> Yes	
Are any present or former employees/dependents currently on or eligible to elect COBRA/State Continuation? <input type="radio"/> No <input type="radio"/> Yes	
If yes, enter information below. Attach a separate sheet if necessary.	

Name of applicant	Qualifying event (e.g., termination of employment, divorce, etc.)	Date of qualifying event	Date COBRA or State Continuation coverage terminates

Employer Agreement

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 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.
- For small employers, you may be charged a monthly administrative fee which will not be more than \$5.00 per person based on coverage selected. For large employers, you may be charged a monthly administrative fee.
- 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 or group contract are met.
- Only individuals who meet the eligibility requirements of the plan are eligible to maintain coverage.
- For medical coverage, you understand that providing fraudulent information or intentional misrepresentation of a material fact including providing incomplete, inaccurate information may void, reduce, or terminate an individual's coverage or the group's coverage. (Health related factors will not be used to void or terminate an individual's medical coverage or a small employer 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.
- The agent/broker/producer has explained to me that Humana has made available to my firm the State Medical Plans prescribed by Texas House Bill 1212, providing that my firm, as defined in the Act, is a small employer of 2-50 eligible employees (this paragraph not applicable to large employers).

This document will form part of any contract issued. Coverage is not in effect unless and until you receive written notification from us.

For large employers, if this application is declined, we will return the premium deposit submitted with this application.

Do not cancel any current group coverage until you receive written notice from us that we have issued coverage.

Dated on: _____
(month, date, year)

By: _____
(employer signature)

Dated at: _____
(city and state)

By: _____
(title)

Agent/Producer Information

1. Agent/Agency of Record (for commissions and correspondence): Name (print) Tax ID / Social Security Number / Humana Agent Number Commission split: <input type="radio"/> No <input type="radio"/> Yes If yes, percentage: (total should equal 100%)	2. Agent/Agency of Record (for split-commissions): Name (print) Tax ID / Social Security Number / Humana Agent Number Percentage of sales: <input type="radio"/> No <input type="radio"/> Yes If yes, percentage: (total should equal 100%)
1. Writing Agent/Producer: Name (print) Social Security Number Commission split: <input type="radio"/> No <input type="radio"/> Yes If yes, percentage: (total should equal 100%)	2. Writing Agent/Producer: Name (print) Social Security Number Percentage of sales: <input type="radio"/> No <input type="radio"/> Yes If yes, percentage: (total should equal 100%)

General Agency

General agency information pertains to Agent/Agency of Record #1 Agent/Agency of Record #2

Name (print)	Tax ID / Humana Agent Number		
Address	City	State	Zip code

As the Writing Agent/Broker/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, including an explanation of the State Medical Plans to employers of 2-50 eligible employees. These provisions are available to me and the employer in the Regulatory Pre-enrollment Disclosure or other plan literature.

Writing Agent's Signature: _____ Date: _____

The following applies to all companies and products

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 group plan 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.

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, 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, Group Plan or Group Contract. 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.

The following applies to medical plans only

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

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. You will receive advance written notice.

For you to remain eligible for the Policy, Group Plan or Group Contract, the eligibility, underwriting and participation requirements must be maintained, for each respective coverage. Failure to maintain the plan eligibility and underwriting requirements will terminate your coverage under the policy. If you fail to meet the participation requirements for 6 consecutive months, your coverage will be terminated on the first renewal date following the end of this 6-month period. Other termination provisions are stated in the Policy, Group Plan or Group Contract.

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 of an individual or medical coverage of a small employer.

otherwise provided under the state law. Entities that are affiliated companies or that are eligible to file a combined tax return for the purpose of taxation, are considered one employer.

HUMANA[®]
Guidance when you need it most

PPO and Classic Medical plans, Life, Vision and Short-Term Income Protection plans insured or administered by Humana Insurance Company. HMO plans offered by Humana Health Plan of Texas, Inc., a Health Maintenance Organization. POS plans offered by Humana Health Plan of Texas, Inc., a Health Maintenance Organization and insured or administered by Humana Insurance Company.

HUMANA[®]
Specialty Benefits

Prepaid and AdvantagePlus dental benefits offered and administered by DentiCare, Inc. (d/b/a CompBenefits). All other Dental plans insured or administered by HumanaDental Insurance Company or Humana Insurance Company. CompBenefits Vision plan insured and administered by CompBenefits Insurance Company.

Humana Small Group Medical

Humana Insurance Company
Humana Health Plan of Texas, Inc.

HMO Premium Billing Address
12296 Collections Center Drive
Chicago, IL 60693

Plan Selection (To complete this information, refer to your proposal.)

	Plan 1	Plan 2	Plan 3
Plan name (as shown on your proposal)			
Office visit copayment (if applicable)	\$	\$	\$
Coinsurance (if applicable)	Participating (In) : % _____ Non-participating (Out): % _____	Participating (In) : % _____ Non-participating (Out): % _____	Participating (In) : % _____ Non-participating (Out): % _____
Deductible (if applicable)	Participating (In): \$ _____ Non-participating (Out): \$ _____	Participating (In): \$ _____ Non-participating (Out): \$ _____	Participating (In): \$ _____ Non-participating (Out): \$ _____
Out-of-pocket limit (if applicable)	Participating: \$ _____ Non-participating: \$ _____	Participating: \$ _____ Non-participating: \$ _____	Participating: \$ _____ Non-participating: \$ _____
Network name (if applicable)			

Plan Riders (Please refer to your proposal for rider availability with plan selected.)

	Plan 1	Plan 2	Plan 3
Deductible Carryover Credit	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
Supplemental Accident	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
Prescription Drug/Retail Card (Level 1 / 2 / 3 / 4)	\$ ____ / \$ ____ / \$ ____ / ____ %	\$ ____ / \$ ____ / \$ ____ / ____ %	\$ ____ / \$ ____ / \$ ____ / ____ %
Prescription Drug/Retail Card (Group A / B / C / D)	\$ ____ a / \$ ____ a / \$ ____ a / \$ ____ a	\$ ____ a / \$ ____ a / \$ ____ a / \$ ____ a	\$ ____ a / \$ ____ a / \$ ____ a / \$ ____ a
Other:	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
Special State Options (not available with Consumer Choice Plans)		PPO and Classic Products	HMO and POS Products
Invitro Fertilization Benefit	<input type="radio"/> No <input type="radio"/> Yes	Optional	Optional
Serious Mental Illness Benefit	<input type="radio"/> No <input type="radio"/> Yes	Optional	Included
If your group is a municipality, county, school district or other political subdivision of the state, this benefit must be provided.			
Speech and Hearing Rider	<input type="radio"/> No <input type="radio"/> Yes	Included	Optional

Consumer Choice Medical Plans

You have the option to choose the Consumer Choice PPO Benefits Health Plan, Consumer Choice HMO Benefits Health Plan, or the Consumer Choice POS Benefits Health Plan that either in whole or in part, does not provide state-mandated health benefits normally required in Texas health benefit plans. A consumer choice standard health benefit plan may provide more affordable health benefits for you and your employees although, at the same time, it may provide you and your employees fewer health benefits than those normally included as state-mandated health benefits in Texas health benefit plans. If you choose a consumer choice standard benefit plan, please consult with your insurance agent to discover which state-mandated health benefits are reduced and/or excluded.

Consumer Choice PPO: No Yes

Consumer Choice HMO: No Yes

Consumer Choice POS: No Yes

Plan Selection (continued)

Below is the Required Disclosure Notice for Group PPO & HMO Consumer Choice Benefit Plans Issued in Texas. To obtain a copy of the required Consumer Choice Disclosure Notice for Consumer Choice POS Benefit Plans Issued in Texas, please consult your insurance agent.

I acknowledge the Consumer Choice PPO Benefits Health Plan, Consumer Choice HMO Benefits Health Plan, or the Consumer Choice POS Benefits Health Plan that either in whole or in part, does not provide state-mandated health benefits normally required in Texas health benefit plans. I am aware a consumer choice standard benefit health plan may provide more affordable health benefits although, at the same time, it may provide fewer health benefits than those normally included as state-mandated health benefits in Texas health benefit plans.

Excluded PPO State Mandates

Chemical & Alcohol Dependency
TMJ
Home Health Care
Serious Mental Illness
Invitro
Speech & Hearing

Excluded HMO State Mandates

Chemical & Alcohol Dependency
Oral Contraceptive Drugs & Devices
TMJ
Serious Mental Illness
Invitro

The Consumer Choice Health Benefit Plans may include requirements and/or restrictions on deductibles, coinsurance, copayments, or annual or lifetime maximum benefit amounts that differ from other PPO & HMO plans. I understand that I may obtain from the Department of Insurance a consumer brochure with more information on Consumer Choice Health Benefit Plans, either by visiting the TDI website at www.tdi.state.tx.us/consumer/indexc.html, or by calling 1-800-252-3439.

(Only sign and complete this section if a Consumer Choice Plan was selected.)

I acknowledge that I was offered the opportunity to apply for an accident and sickness insurance policy or evidence of coverage in the same category that most closely approximates the consumer choice health benefit plan offered.

Group Representative Signature: _____

Title: _____ Date Signed: _____

Underwriting Requirements

- You may not sponsor a medical plan from a carrier other than Humana.
- Medical coverage is available to employers with two or more enrolled employees.
- If the only employees of a two-life group are husband and wife, each must enroll separately as an employee and maintain eligibility. The group is only eligible if a bona fide business entity exists.
- Minimum employer contribution toward employee premium is 50%.
- Retirees of a small employer are not eligible for retiree coverage.
- There are no excluded class options for small group medical coverage.
- If you do not maintain eligibility, underwriting, and participation requirements, we will terminate your coverage.

Participation

- All plans – 75%

Group Information

How much will you contribute to premium? Employee _____% Dependent _____%

Are there any other entities associated with this company that are eligible to file a combined tax return? No Yes
If yes, enter information below.

Company Name	Total Employees

Will your employees have access to another carrier's medical coverage by virtue of their employment with you? No Yes
If yes, name of carrier: _____

Did you have prior group medical coverage? No Yes If yes, submit most recent carrier billing with effective and termination dates. _____

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

Is the agent/broker/producer representing you for this application your current agent/broker/producer of record? No Yes _____

Group Information (continued)

Provide the current and renewal medical insurance premium rates below and attach a copy of your most recent premium bill.

Date of renewal:

<p>Current Plan 1 current carrier rates:</p> <p>Employee: \$ _____ Spouse: \$ _____ Child(ren): \$ _____ Family: \$ _____</p> <p>Plan design: _____</p> <p>Office visit copay: _____</p> <p>Per confinement copay: _____</p> <p>Deductible: • Participating _____ • Non-participating _____</p> <p>Out-of-pocket: • Participating _____ • Non-participating _____</p> <p>Coinsurance stoploss: • Participating _____ • Non-participating _____</p> <p>Emergency room copay: _____</p> <p>Prescription drug benefit: _____</p> <p>Do you as the employer currently fund any of the plan deductible for the employees? <input type="radio"/> No <input type="radio"/> Yes If yes, how much of the deductible do you fund? _____</p> <p>Renewal rates: In the parentheses, please indicate the number of employees enrolled in each tier, if available.</p> <p>Employee (): \$ _____ Spouse (): \$ _____ Child(ren) (): \$ _____ Family (): \$ _____</p>	<p>Current Plan 2 current carrier rates:</p> <p>Employee: \$ _____ Spouse: \$ _____ Child(ren): \$ _____ Family: \$ _____</p> <p>Plan design: _____</p> <p>Office visit copay: _____</p> <p>Per confinement copay: _____</p> <p>Deductible: • Participating _____ • Non-participating _____</p> <p>Out-of-pocket: • Participating _____ • Non-participating _____</p> <p>Coinsurance stoploss: • Participating _____ • Non-participating _____</p> <p>Emergency room copay: _____</p> <p>Prescription drug benefit: _____</p> <p>Do you as the employer currently fund any of the plan deductible for the employees? <input type="radio"/> No <input type="radio"/> Yes If yes, how much of the deductible do you fund? _____</p> <p>Renewal rates: In the parentheses, please indicate the number of employees enrolled in each tier, if available.</p> <p>Employee (): \$ _____ Spouse (): \$ _____ Child(ren) (): \$ _____ Family (): \$ _____</p>
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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 in a treatment facility;
 - who incurred more than \$10,000 of medical expenses in the past 24 months;
 - who has been advised within the last 90 days to have surgery or be hospitalized;
 - 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: (check all that apply)
 - AIDS or an AIDS-related complex or other immune system disorder
 - Alcohol or drug abuse or dependence, or psychological disorder
 - Cancer or cancerous tumor
 - Heart or vascular disease or stroke
 - Diabetes or any disease or disorder of the kidneys, liver or lungs
 - Systemic disease including, but not limited to Lupus, Multiple Sclerosis, or Muscular Dystrophy
 - Organ transplant (other than corneal)

If you answered yes to questions 1-3 above, please indicate the question number and explanation.

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

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.

Retiree Information

Are you offering coverage to retirees? No Yes If yes, required age: _____ Minimum years of service: _____

Please refer to your proposal to complete this application. This document will form part of any contract issued. Print clearly in black ink, and answer all questions or indicate "not applicable".

Plan Selection

Is this a SmartSuite selection? No Yes

	Plan 1	Plan 2
Plan Name (as shown on your proposal)		
Coinsurance:	Participating (In) : % ____/____/____ Non-participating (Out): % ____/____/____	Participating (In) : % ____/____/____ Non-participating (Out): % ____/____/____
Deductible:	\$	\$
Annual Maximum:	\$	\$
Preventive Services Deductible Options:	<input type="radio"/> Apply Deductible <input type="radio"/> Waive Deductible	<input type="radio"/> Apply Deductible <input type="radio"/> Waive Deductible
Periodontic/Endodontic Options:	<input type="radio"/> Basic <input type="radio"/> Major	<input type="radio"/> Basic <input type="radio"/> Major
Orthodontia Options:	<input type="radio"/> Child Only: Lifetime Orthodontia Maximum \$ _____ <input type="radio"/> Adult And Child: Lifetime Orthodontia Maximum \$ _____	
Composite Fillings for Molars:	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
Implant Coverage:	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
Out of network reimbursement options:	<input type="radio"/> Maximum allowable fee <input type="radio"/> In-network fee schedule	<input type="radio"/> Maximum allowable fee <input type="radio"/> In-network fee schedule
Open Enrollment:	<input type="radio"/> No <input type="radio"/> Yes	

Underwriting Requirements

- Underwriting approval is required to offer more than one dental carrier to your employees.
- Dental coverage is available to employers with two or more enrolled employees.
- If the only employees of a two-life group are husband and wife, each must enroll separately as an employee and maintain eligibility. The group is only eligible if a bona fide business entity exists.
- Minimum employer contribution toward employee premium is 25%. This minimum does not apply to Voluntary coverage.
- Retiree coverage is available to employers with 51 or more enrolled employees.
- Minimum age for retiree coverage is 50.
- Excluded class options: hourly, salary, union, non-union, management, non-management.
- If you do not maintain eligibility, underwriting, and participation requirements, we will terminate your coverage.

Participation requirements:

Eligible Employees	Participation
2+ (Employer Pays 100% of Premium)	100%
2+ (Employees Contribute to Premium)	75%
2+ Eligible Employees with Spousal Waiver	50%

Voluntary Participation Requirements:

Eligible Employees	Participation
Traditional Preferred, PPO, Preventive Plus	
2+ Employees	Two enrolled employees or 25% whichever is greater.
Advantage Plus	
10+ Employees	Ten enrolled employees or 25% whichever is greater
Prepaid	
2+ Employees	Two or more enrolled employees
Prepaid with orthodontia coverage	
10+ employees	Ten or more employees

Group Information

How much will you contribute to premium? Employee _____% Dependent _____%

Are you offering dental coverage to retirees? No Yes If yes, required age: _____ Minimum years of service: _____

Did you have prior group dental coverage? No Yes
If yes, submit most recent carrier billing with effective and termination dates.

Did your prior dental coverage include orthodontia? No Yes

Will your employees have access to another carrier's dental coverage by virtue of their employment with you? No Yes
If yes, name of carrier: _____

Please refer to your proposal to complete this information. This document will form part of any contract issued.

Plan Selection

	Plan 1	Plan 2
Plan Name (as shown on your proposal)		
Open Enrollment:	<input type="radio"/> No <input type="radio"/> Yes	

Group Information

How much will you contribute to premium? Employee _____% Dependent _____%

Are you offering vision coverage to retirees? No Yes If yes, required age: _____ Minimum years of service: _____

Will your employees have access to another carrier's vision coverage by virtue of their employment with you? No Yes
If yes, name of carrier: _____

Thank you for choosing Humana.

Humana National POS 11 Copay

Form CCP Figure 1

TEXAS DEPARTMENT OF INSURANCE REQUIRED DISCLOSURE NOTICE FOR ALL GROUP CONSUMER CHOICE POINT OF SERVICE (POS) BENEFIT PLANS ISSUED IN TEXAS

As required by 28 TAC §21.3530, I have been informed that the Consumer Choice Standard Benefit Plan that I am purchasing does not include all state mandated health insurance benefits. I understand that the following benefits are provided at a reduced level from what is mandated, or are Excluded completely from the plan:

Mandated Benefit Description	Benefit Reduced	Benefit Excluded
Outpatient Physician Services	Subject to Deductible	
Advanced Diagnostic Imaging (PET, CAT, MRI, MRA, SPECT)	Subject to Deductible	
Therapeutic Radiology Services	Subject to Deductible	
Home Health Services	Subject to Deductible	
Inpatient Hospital Services	Subject to Deductible	
Inpatient Physician Care Services	Subject to Deductible	
Outpatient Hospital Services	Subject to Deductible	
Breast Reconstruction after mastectomy	Subject to Deductible	
Prenatal Services	Subject to Deductible	
Diabetes Self-managment Training and Equipment	Subject to Deductible	
Outpatient Visit Limits for Basic Mental Health, Chemical and Alcohol Dependency (no limits apply to groups with 51-99 employees)	20 Visit Limit Combined	
Inpatient Day Limits for Basic Mental Health, Chemical and Alcohol Dependency (no limits apply to groups with 51-99 employees)	Subject to Deductible & 10 Day Limit Combined	
Outpatient Rehabilitation Therapies: Physical, Speech, Cognitive, Audiology, Occupational, Manipulations, Adjustments and Modalities	30 Visit Limit Combined	
Serious Mental Illness (including offer rider for groups with 2-50 employees)	Subject to Deductible	
Inability to undergo Dental Treatment	Subject to Deductible	
Hearing Aids	Subject to Deductible	
TMJ	Subject to Deductible	
In-vitro Fertilization Services		Excluded
Rehabilitative services for children	Subject to Deductible	
Acquired brain injury	Subject to Deductible	
Reconstructive surgery for craniofacial abnormalities	Subject to Deductible	
Telemedicine	Subject to Deductible	
Treatment for HIV related illness	Subject to Deductible	
Treatment for PKU/ amino acids	Subject to Deductible	
Autism	Subject to Deductible	
Prosthetics & Orthotics	Subject to Deductible	
Contraceptive devices	Subject to Deductible	

This POS Consumer Choice Health Benefit Plan may include requirements and/or restrictions on deductibles, coinsurance, copayments, or annual or lifetime maximum benefit amounts that differ from other POS plans. I understand that I may obtain from the Department of Insurance a consumer brochure with more information on Consumer Choice Health Benefit Plans, either by visiting the TDI website at www.tdi.state.tx.us/consumer/indexc.html, or by calling 1-800-252-3439.

Signature of Applicant

Name of Applicant

Date

Name of Business (if applicable)

Address

City

State

Zip

Note: This form must be retained by the carrier issuing the policy and must be provided to the Commissioner of Insurance upon request. You have the right to a copy of this written disclosure statement free of charge. A new form must be completed upon each subsequent renewal of this policy.

2-50 new business enrollment checklist

Please submit this form with sold case

Group name: _____

Humana sales representative name: _____

Complete employer group application:

- Your business profile
- General eligibility
- Employer agreement
- Agent/producer information sign & date
- Medical plan selection form
- Dental plan selection form
- Short-term income protection selection form
- Life plan selection form

Additional employer requirements:

- Check for first month's premium made payable to: **Humana Inc.**
(administrative fee may apply—ask sales representative)
- Humana quote for the requested effective date with sold plan circled
- Copy of current carrier's most recent billing statement
- Copy of the company's most recent state wage and tax statement. Status of all employees must be written on wage and tax (full time, part time, waiving, terminated and termination date)
- Eligibility Certification Form for all employees **NOT** listed on the wage and tax statement
- Full Time Employment Questionnaire and a copy of 1099 form are needed for contracted/commissioned employees taking coverage

For specialty groups such as non-profit, partnerships, MLAs, newly formed companies without wage and tax, and PEO groups, contact your sales representative for additional requirements.

Employee enrollment application:

- All sections completed, signed and dated
- Completed waivers on all eligible employees waiving coverage unless using dental/life list enrollment.
- Application or waiver from all employees currently within COBRA/state continuation period
- Any medical information on application or additional page must be signed and dated by applicant (and spouse if taking employee and spouse coverage) prior to the effective date

Notes: _____

Do not cancel current coverage until you receive written notification of coverage with Humana.

HUMANA
Guidance when you need it most