1-50 Employer / Group Coversheet - UTAH

Medical group set-up form

Requested effective date:	Group number:	Quote number:
Full legal business name:		
Corporate / Situs location street address (P.O. Box not allowed):		
City, State, ZIP:	Business phone number:	
Type of business: ❑ Corporation ❑ Partnership ❑ Sole Proprietorship ❑ Church or government entity ❑ Other (explain):		
Federal Tax ID:	Date company established:	Do you have more than one location? ❑ No ❑ Yes
Benefit Administrator / Management contact name:		Phone number:
Benefit Administrator / Management contact email address:		

Eligibility Requirements:

Number of employees on payroll:	Total number of eligible employees:
Number of hours worked per week to be eligible (select between 20 and 40 hours):	
Number of employees in a probationary waiting period (do not include in the eligible count below):	
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. 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): ❑ First of month following probationary waiting period (required for HMO plans requiring referrals) ❑ Immediately following probationary waiting period (required for 90 day probationary waiting period)	
For groups 26+, are you offering coverage to retirees? ❑ No ❑ Yes	
Do you wish to offer Domestic Partner coverage? ❑ No ❑ Yes	
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:	
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, provide company name and total employees:	

COBRA / State Continuation:

Are any present or former employees / dependents currently on or eligible to elect COBRA / State Continuation? ❑ No ❑ Yes
If yes, then enter information below. Attach additional, signed and dated sheets, if necessary.

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

Employer Contribution:

Do you as an employer currently fund any of the plan deductible for the employees? ❑ No ❑ Yes

If yes, indicate amount funded $_____ Employer's contribution for medical: Employee _____ Dependent _____

Other change requests (existing business only): _____

Medical plans	Plan 1	Plan 2	Plan 3
Plan name (as shown in your proposal; include network name and optional riders, if applicable)			

Do you wish to have 24-hour coverage for employees not covered by Workers' Compensation? ❑ No ❑ Yes

If yes, list name(s): _____

Agreement and Signature (review your policy / certificate carefully)

You the employer, policyholder, contract holder, or Certificate sponsor understand, agree and represent: You have read this Employer/Group Application (EGA) 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 the quote and the applicable required regulatory information. 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. For action to be taken on this EGA, the first month's estimated premium (which may include a monthly administrative fee) and fully completed enrollment information for all employees and dependents must be submitted with the EGA. Coverage is not in effect unless and until you receive written notification from us. You will provide the documentation requested by us which establishes that all eligibility, underwriting, and participation requirements of the plan are met. 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. Providing incomplete, inaccurate, or untimely information may void, reduce, or increase past premium, or terminate an individual's coverage or the group's coverage. This EGA will form part of any contract or coverage issued. If this EGA 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.

Any person who knowingly presents false information in an application for insurance or life settlement contract is guilty of a crime and, upon conviction, may be subject to fines or confinement in prison, or both.

If you decide not to sign this EGA, 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 (MM/DD/YY): _____ at _____(city and state)

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

Agent / Broker / Producer Information:

1. Agency of Record (for commissions and correspondence)	**2. Agent / Agency of Record (for split commissions)**
Name (print or type): Stone Hill National	Name (print or type): N/A
Tax ID / Social Security Number / Humana agent number: 1084010	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 / Broker / Producer	**2. Writing Agent / Broker / Producer** N/A
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%):
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:
As the Writing Agent/Broker/Producer, I acknowledge that I am responsible to meet with the employer 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 employer in the Regulatory Pre-enrollment Disclosure Guide or other plan literature.	
Writing Agent / Broker / Producer's signature:	Date:

Humana.

Employer Application

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Guidance when you need it most

UNDERWRITING REQUIREMENTS

Medical groups less than 100 employees

You, the participating employer, policyholder, contractholder, or group plan sponsor, may not establish, sponsor, and endorse 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. If less than 10 employees are enrolled, you must submit evidence of health status for all employees and dependents. Humana will not use the evidence of health status to decline medical coverage. Minimum employer contribution toward employee premium is 50%. Retiree coverage is available to employers with 26 or more enrolled employees. Minimum age for retiree coverage is 65 for employers with 26 to 50 enrolled employees. There are no excluded class options for small group medical coverage. If you do not maintain eligibility, underwriting, and participation requirements, Humana will terminate your coverage

Participation

Non-contributory plans	100%
Contributory plans	75%

For IL, IN, KY, LA, MI, OH, TN, SC, MS and VA: For groups of 2-4 eligible employees, Humana requires 75% participation with a minimum enrollment of two. For groups of 5+ eligible employees, Humana requires 75% participation, but will allow 50% participation if the difference is due to valid waivers.

Medical groups more than 100 employees

Refer to your proposal for complete underwriting requirements. Underwriting approval is required to offer more than one medical carrier to your employees. If you do not maintain eligibility, underwriting, and participation requirements, Humana will terminate your coverage.

Dental

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 26 or more enrolled employees. Minimum age for retiree coverage is 65 for employers with 26 to 50 enrolled employees and must be at least 50 for 51+ enrolled employees. Excluded class options: hourly, salary, union, non-union, management, non-management. If you do not maintain eligibility, underwriting, and participation requirements, Humana 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
2+ employees	Two enrolled employees or 25%, whichever is greater.

Life

Basic Life coverage is available to employers with two or more enrolled employees. Voluntary life coverage is available to employers with five 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%. This minimum does not apply to voluntary coverage. Retirees are not eligible for life coverage. Excluded class options: hourly, salary, union, non-union, management, non-management.If you do not maintain eligibility, underwriting, and participation requirements, Humana will terminate your coverage. Single medical carrier: You must have 100% participation of all eligible employees for this coverage, regardless of whether they have medical coverage through their spouse for non-contributory plans. For contributory plans, 75% participation required; minimum employer contribution 50%. Multiple medical carrier: If you offer more than one medical carrier, you must enroll 100% of those employees who take our coverage regardless of the percentage of contribution paid by you. Five employees or 25%, whichever is greater.

Participation requirements

Non-contributory plans	100%
Contributory plans	75%

Vision

Underwriting approval is required to offer more than one vision carrier to your employees. Vision 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 74%. Less than 75% requires the selection of a Voluntary Vision product. Retiree coverage is available to employers with 26 or more enrolled employees. Minimum age for retiree coverage is age 65 for employers with 26 to 50 enrolled employees and must be at least age 50 for 51+ enrolled employees. Excluded class options: hourly, salary, union, non-union, management, non-management. If you do not maintain eligibility, underwriting and participation requirements, Humana will terminate your coverage. Dual choicing Vision products is prohibited.

Participation requirements:
10 or more enrolled employees
Group sizes of 2-9 considered if sold with a medical or dental plan with a minimum of 25% participation and no fewer than two enrolled employees.

Vision Multiple Choice options
Multiple choice arrangements are not offered for groups with 2-99 lives. For 100+ groups dual-choice arrangements are subject to underwriting review and prior approval.