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.

1-50 Employer/Group Application - Utah

Dental & Vision

Humana.com

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in the Small Group/Employer Application as "Humana".

Dental plans insured or administered by HumanaDental Insurance Company or Humana Insurance Company. Dental EPO plans insured or administered by Humana Medical Plan of Utah, Inc. Vision plans insured or administered by Humana 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	ZIP code	County
Type of business ☐ Corporation ☐ Partnership ☐ Sole Proprietorship ☐ Church or Government entity ☐ 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:				
Billing address (N/A, if same as street address)	City	State	ZIP code	
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.				

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	Dental	Vision
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			

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)

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.

Employee effective provision: (The employee termination date coincides with the effective date provision.)
☐ First of month following probationary waiting period
☐ Immediately following probationary waiting period (required for 90 day probationary waiting period)
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

2. ELIGIBILITY REQUIREMENTS (continued)

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:_____

Employee Eligibility by Class
According to Federal health care reform, an employer's group health plan cannot discriminate in favor of highly-compensated employees. Doing so may result in a penalty. To avoid penalties, please review any class-based benefits with your legal or financial advisor to ensure your group health plan does not favor highly compensated employees. (Excludes grandfathered health plans).

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)

Do you wish to offer Domestic Partner coverage? ☐ No ☐ Yes

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

Which plan(s) are you offering? ☐ Medicare + Choice ☐ Other (list plan):_____	Do you wish to offer coverage to dependents of retirees? (Medicare + Choice not available?) ☐ No ☐ Yes
Who should receive the premium bill? ☐ Employer ☐ Retiree	

	All	Dental	Vision
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

3. COBRA/STATE CONTINUATION

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

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 UT-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 - Employer's contribution for: (Indicate $ or % amount)	**Dental**	**Vision**
Employee		
Employee/spouse		
Employee/child		
Family		

5. PRIOR/CURRENT CARRIER INFORMATION

	Dental	**Vision**
Is this group transferring from another group carrier?	☐ No ☐ Yes	☐ No ☐ Yes
If yes, provide carrier name		
Proposed termination date		
Dental only: Did prior dental coverage include orthodontia? ☐ No ☐ Yes		

6. PRODUCT SELECTION - To complete this section, please refer to the Underwriting Requirements (reorder UT-52347). Please refer to your quote for the plan's name. Also review the Regulatory Pre-enrollment Disclosure Guide with your agent, broker, or producer.

a. DENTAL PLANS (all group sizes)

	Plan 1	**Plan 2**
Plan name (as shown on your proposal)		
Funding type	☐ Employer sponsored ☐ Voluntary	☐ Employer 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
Oral Surgery Covered in Basic	☐ No ☐ Yes	☐ No ☐ Yes
Open Enrollment	☐ No ☐ Yes	

b. VISION PLANS (all group sizes)

Plan name (as shown on your proposal)

7. THE FOLLOWING APPLIES TO ALL COMPANIES AND PLANS

The companies listed on this Employer Group Application (EGA), severally or collectively as the context may require, are referred to in this EGA as we, us, and our.

In accordance with Section 503 of ERISA, as claims administrator we have authority to make decisions consistent with the terms of the Policy or Certificate regarding (1) eligibility for coverage; (2) paying claims for benefits; (3) interpretation of Policy or Certificate provisions; and (4) resolution of factual questions relating to coverage and benefits.

You, the participating employer, policyholder, contractholder, or Certificate sponsor, intend to establish, sponsor, plan 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.

8. THE FOLLOWING APPLIES TO ALL COMPANIES AND PLANS

You agree to make available your records which we determine are relevant to this EGA and group coverage for inspection by the Trustee, Administrator, us, or our representative during your normal business hours.

If you fail to pay premium when due, coverage may be subject to termination as specified under the terms of the Policy or Certificate. 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. You will receive advance written notice.

For you to remain eligible for the Policy or Certificate, the eligibility, underwriting, participation, and contribution requirements must be maintained, for each respective coverage.

Failure to maintain the plan eligibility, underwriting, participation and contribution requirements will terminate your coverage under the Policy or Certificate.

We have the right to use information provided by you and any employee, dependent or individual to determine whether this EGA will be accepted or declined and to establish appropriate premiums. We will not use any health-related information to decline coverage to an employee, dependent or individual if this EGA is accepted. We will administer this in a non-discriminatory manner.

9. 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 policy/certificate provides limited benefits. Review your policy/certificate carefully.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.

A person that knowingly presents false information in an application for insurance or a viatical settlement is guilty of a crime and may be subject to fines and confinement in prison.

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

By: _____ _____ _____

(Employer printed name) (Employer signature) (Title)

10. AGENT/BROKER/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/Broker/Producer	**2. Writing Agent/Broker/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/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 Insurance Company, 1100 Employers Blvd., Green Bay, WI 54344 Humana Dental Insurance Company, 1100 Employers Blvd., Green Bay, WI 54344 Humana Medical Plan of Utah, Inc., 9815 S. Monroe Street, Ste. 300, Sandy, UT 84070

1-50 Employer/Group Application - Utah

Life

Humana.com

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in the Small Group/Employer Application as "Humana".

Life plans insured or adminisered by Humana Insurance Company or 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	ZIP code	County
Type of business ☐ Corporation ☐ Partnership ☐ Sole Proprietorship ☐ Church or Government entity ☐ 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:				
Billing address (N/A, if same as street address)	City	State	ZIP code	
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.				
For Workplace Voluntary Benefits: Effective date of policy and due date of first premium will be (month, day, year) _ _ / _ _ / _ _ _ _				

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.

	Life	Workplace Voluntary Benefits
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		

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)

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.

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)

2. ELIGIBILITY REQUIREMENTS (continued)

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:_____

Employee Eligibility by Class
According to Federal health care reform, an employer's group health plan cannot discriminate in favor of highly-compensated employees. Doing so may result in a penalty. To avoid penalties, please review any class-based benefits with your legal or financial advisor to ensure your group health plan does not favor highly compensated employees. (Excludes grandfathered health plans).

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)

Do you wish to offer Domestic Partner coverage? ☐ No ☐ Yes

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

Which plan(s) are you offering? ☐ Medicare + Choice ☐ Other (list plan):_____	Do you wish to offer coverage to dependents of retirees? (Medicare + Choice not available?) ☐ No ☐ Yes

Who should receive the premium bill? ☐ Employer ☐ Retiree

	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**

3. EMPLOYER CONTRIBUTION(S)

Coverage - Employer's contribution for: (Indicate $ or % amount)	**Life**	**Voluntary Life**	**Workplace Voluntary Benefits**
Employee			
Employee/spouse			
Employee/child			
Family			

4. PRIOR/CURRENT CARRIER INFORMATION

	Life
Is this group transferring from another group carrier?	☐ No ☐ Yes
If yes, provide carrier name	
Proposed termination date	

5. PRODUCT SELECTION - To complete this section, please refer to the Underwriting Requirements (reorder UT-52347). Please refer to your quote for the plan's name. Also review the Regulatory Pre-enrollment Disclosure Guide with your agent, broker, or producer.

a. LIFE - Please refer to your proposal

Basic Life

Basic Employee Life and AD&D ☐ No ☐ Yes

☐ Flat amount—indicate level: $_____

☐ Salary plan—options are .5x to 7x salary (in .5 increments), rounded to the next highest $1,000. Indicate salary level: _____ x salary
Maximum benefit $_____

☐ 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	Choose Flat Amount or Salary Level (Must match for all classes)
1.		
2.		
3.		
4.		

Rate Guarantee ☐ 2 Year ☐ 3 Year

Age Reduction (Refer to your proposal) Schedule 1 _____ Schedule 2 _____ Schedule 3 _____

Basic and Voluntary Age Reduction schedules must match.

Basic Dependent Life ☐ No ☐ Yes

If yes, indicate volume amount

☐ Spouse $20,000; Dependent Age 6 Months to 26 Years $5,000, Dependent Age 15 Days to 6 Months $1,000, Birth through 14 Days No Benefit

☐ Spouse $10,000; Dependent Age 6 Months to 26 Years $2,500, Dependent Age 15 Days to 6 Months $500, Birth through 14 Days No Benefit

☐ Spouse $5,000; Dependent Age 6 Months to 26 Years $1,000, Dependent Age 15 Days to 6 Months $500, Birth through 14 Days No Benefit

☐ Spouse $20,000; Dependent Age 6 Months to 26 Years $10,000, Dependent Age 15 Days to 6 Months, $500, Birth through 14 days No Benefit

☐ Spouse $10,000; Dependent Age 6 Months to 26 Years $5,000, Dependent Age 15 Days to 6 Months $500, Birth through 14 Days No Benefit

☐ Spouse $10,000; Dependent Age 6 Months to 26 Years $10,000, Dependent Age 15 Days to 6 Months $500, Birth through 14 Days No Benefit

Voluntary Life

Voluntary Employee Life ☐ No ☐ Yes

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

Flat amount—indicate level: $_____

☐ Minimum amount $_____

☐ Maximum benefit $_____

Voluntary Dependent Life ☐ No ☐ Yes

(Only available if Employee Voluntary Life is chosen)

Dependent Child Voluntary Amount ☐ $5,000 ☐ $10,000

Rate Guarantee ☐ 2 Year ☐ 3 Year

Age Reduction (Refer to your proposal) Schedule 1 _____ Schedule 2 _____ Schedule 3 _____

Basic and Voluntary Age Reduction schedules must match.

Portability of coverage (Applicable to Voluntary Life only) Groups 1-100: Included (Unless mandated by state)

Will the insurance coverage applied for be used to replace existing life coverage? ☐ No ☐ Yes

b. WORKPLACE VOLUNTARY BENEFITS (all group sizes)

CRITICAL LIFE ☐ No ☐ Yes **Optional Benefits - Employer Selectable**	**Plan design** ☐ 10 Year ☐ 20 Year ☐ Waiver of premium ☐ Loss of work ☐ Takeover ☐ Additional benefit increase ☐ Accelerated living benefit - critical illness _____% ☐ Accidental death and loss of sight dismemberment	
WHOLE LIFE **Optional Riders**	☐ Whole Life 65 ☐ Whole Life 99 ☐ Waiver of premium ☐ AD&D ☐ Loss of work ☐ Automatic benefit increase ☐ Family Term ☐ Employee Term to Age 65	

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

The companies listed on this Employer Group Application (EGA), severally or collectively as the context may require, are referred to in this EGA as we, us, and our.

In accordance with Section 503 of ERISA, as claims administrator we have authority to make decisions consistent with the terms of the Policy or Certificate regarding (1) eligibility for coverage; (2) paying claims for benefits; (3) interpretation of Policy or Certificate provisions; and (4) resolution of factual questions relating to coverage and benefits.

You, the participating employer, policyholder, contractholder, or Certificate sponsor, intend to establish, sponsor, plan 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.

7. THE FOLLOWING APPLIES TO ALL COMPANIES AND PLANS

You agree to make available your records which we determine are relevant to this EGA and group coverage for inspection by the Trustee, Administrator, us, or our representative during your normal business hours.

If you fail to pay premium when due, coverage may be subject to termination as specified under the terms of the Policy or Certificate. 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. You will receive advance written notice.

For you to remain eligible for the Policy or Certificate, the eligibility, underwriting, participation, and contribution requirements must be maintained, for each respective coverage.

Failure to maintain the plan eligibility, underwriting, participation and contribution requirements will terminate your coverage under the Policy or Certificate.

We have the right to use information provided by you and any employee, dependent or individual to determine whether this EGA will be accepted or declined and to establish appropriate premiums. We will not use any health-related information to decline coverage to an employee, dependent or individual if this EGA is accepted. We will administer this in a non-discriminatory manner.

8. 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 policy/certificate provides limited benefits. Review your policy/certificate carefully.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.

A person that knowingly presents false information in an application for insurance or a viatical settlement is guilty of a crime and may be subject to fines and confinement in prison.

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: _____ (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/BROKER/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/Broker/Producer	**2. Writing Agent/Broker/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/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 Insurance Company, 1100 Employers Blvd., Green Bay, WI 54344 Kanawha Insurance Company, 210 S. White Street, Lancaster, SC 29720

1-50 Employer/Group Application - Utah

Individual Products

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in the Small Group/Employer Application as "Kanawha". Short Term Disability,and Long Term Disability,and Workplace Voluntary Benefits plans insured or administered 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	ZIP code	County
Type of business ☐ Corporation ☐ Partnership ☐ Sole Proprietorship ☐ Church or Government entity ☐ 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 _____				
Billing contact name:				
Billing address (N/A, if same as street address)	City	State	ZIP code	
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.				
For Workplace Voluntary Benefits: Effective date of policy and due date of first premium will be (month, day, year) _ _ / _ _ / _ _ _ _				

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.

	STD	LTD	Group Critical Illness	Workplace Voluntary Benefits
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				
Number of employees:				
• waiving with other qualifying coverage				
• waiving without other qualifying coverage				
Number of employees to be enrolled				

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.
Medical probationary waiting period must not exceed 90 days.

2. ELIGIBILITY REQUIREMENTS (continued)

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)

STD/LTD only (Employee termination date is last day of employment.)
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

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:_____

Employee Eligibility by Class
According to Federal health care reform, an employer's group health plan cannot discriminate in favor of highly-compensated employees. Doing so may result in a penalty. To avoid penalties, please review any class-based benefits with your legal or financial advisor to ensure your group health plan does not favor highly compensated employees. (Excludes grandfathered health plans).

Has this group been insured by Kanawha 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)

Do you wish to offer Domestic Partner coverage? ☐ No ☐ Yes

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

	All
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

Short Term Disability, Long Term Disability, and Group Critical Illness only

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

Evidence of Insurability required if amount of coverage applied for exceeds amounts below:

	Class 1	Class 2		Class 1	Class 2
Employee STD	$	$	Basic group critical illness	$	$
Employee LTD	$	$	Buy-up group critical illness		

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

W-2 Services Option (Please choose one)
☐ Option 1: Withhold state and federal income taxes, and the employee's portion of FICA. Prepare and file W-2 forms.
☐ Option 2: Withhold federal income taxes, and the employee's portion of FICA. Applicant waives W-2 forms services.

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

3. EMPLOYER CONTRIBUTION(S)

(STD and LTD only) Are employer contributions taxed in employee's paycheck? ☐ No ☐ Yes

Coverage - Employer's contribution for: (Indicate $ or % amount)	STD	LTD	Workplace Voluntary Benefits
Employee			
Employee/spouse	N/A	N/A	
Employee/child	N/A	N/A	
Family	N/A	N/A	

4. PRIOR/CURRENT CARRIER INFORMATION

	STD	LTD
Is this group transferring from another group carrier?	☐ No ☐ Yes	☐ No ☐ Yes
If yes, provide carrier name		
Proposed termination date		

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_____

5. PRODUCT SELECTION - To complete this section, please refer to the Underwriting Requirements (reorder UT-52347). Please refer to your quote for the plan's name. Also review the Regulatory Pre-enrollment Disclosure Guide with your agent, broker, or producer.

a. SHORT TERM DISABILITY (group sizes 2-9). Attach additional signed and dated sheets (reorder UT-52336), if necessary.

	Name of Class 1	Name of Class 2
Funding type	☐ Contributory ☐ Non-contributory	☐ Contributory ☐ Non-contributory
Benefit schedule (select one)	☐ 60% ☐ Flat amount $ _____	☐ 60% ☐ Flat amount $ _____
Weekly benefit minimum	$25.00	$25.00
Weekly benefit maximum	$	$
Earnings definition	■ Base Salary	■ Base Salary
Duration weeks	☐ 13 ☐ 26	☐ 13 ☐ 26
Elimination period (accident/ sickness)	☐ 1/8 ☐ 8/8 ☐ 15/15 ☐ 30/30	☐ 1/8 ☐ 8/8 ☐ 15/15 ☐ 30/30
Pre-existing limitation	■ 3/12	■ 3/12
Rate guarantee	■ 2 Years	■ 2 Years

b. LONG TERM DISABILITY (group sizes 2-9). Attach additional signed and dated sheets (reorder UT-52336), if necessary.

	Name of Class 1	Name of Class 2
Funding type	☐ Contributory ☐ Non-contributory	☐ Contributory ☐ Non-contributory
Benefit schedule (select one)	■ 60%	■ 60%
Monthly benefit minimum	■ Greater of $100 or 10% of monthly income loss	■ Greater of $100 or 10% of monthly income loss
Monthly benefit maximum	$	$
Duration	☐ 5 Years ☐ SSNRA	☐ 5 Years ☐ SSNRA
Elimination period	Days: ☐ 90 ☐ 180	Days: ☐ 90 ☐ 180
Definition of disability	Year own occupation: ■ 2	Year own occupation: ■ 2
Pre-existing limitation	■ 12/24	■ 12/24
Mental health and substance abuse limitation	■ 24-month outpatient	■ 24-month outpatient
Rate guarantee	■ 2 Years	■ 2 Years
Survivor income benefit	■ 3 month gross lump sum	■ 3 month gross lump sum

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

Name of Class 1	
Funding type	☐ Contributory ☐ Non-contributory ☐ Voluntary
Benefit schedule (select one)	☐ 50% ☐ 60% ☐ 66.67% ☐ Other _____ ☐ Flat amount $ _____
Weekly benefit minimum	$25.00
Weekly benefit maximum	$
Earnings definition	■ Base Salary
Duration weeks	☐ 13 ☐ 26 ☐ 52 ☐ Other _____
Elimination period (Accident/Sickness)	☐ 1/8 ☐ 8/8 ☐ 15/15 ☐ 30/30 ☐ Other _____
Pre-existing limitation	☐ None ☐ 3/12 ☐ 6/12 ☐ Other _____
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 $ _____
Weekly benefit minimum	$25.00
Weekly benefit maximum	$
Earnings definition	■ Base Salary
Duration weeks	☐ 13 ☐ 26 ☐ 52 ☐ Other _____
Elimination period (Accident/Sickness)	☐ 1/8 ☐ 8/8 ☐ 15/15 ☐ 30/30 ☐ Other _____
Pre-existing limitation	☐ None ☐ 3/12 ☐ 6/12 ☐ Other _____
Rate guarantee	☐ 1 Year ☐ 2 Years ☐ Other _____

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

Name of Class 1	
Funding type	☐ Contributory ☐ Non-contributory ☐ Voluntary
Benefit schedule (select one)	☐ 50% ☐ 60% ☐ 66.67% ☐ Other _____
Monthly benefit minimum	■ Greater of $100 or 10% of Monthly Income Loss
Monthly benefit maximum	$
Earnings definition	■ Base Salary
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	☐ 3/3/12 ☐ 6/6/12 ☐ 12/12/24 ☐ 3/6/12 ☐ 6/6/24 ☐ 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 _____

d. LONG TERM DISABILITY (group sizes 10+) (continued)

Name of Class 2	
Funding type	☐ Contributory ☐ Non-contributory ☐ Voluntary
Benefit schedule (select one)	☐ 50% ☐ 60% ☐ 66.67% ☐ Other _____
Monthly benefit minimum	■ Greater of $100 or 10% of Monthly Income Loss
Monthly benefit maximum	$
Earnings definition	■ Base Salary
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	☐ 3/3/12 ☐ 6/6/12 ☐ 12/12/24 ☐ 3/6/12 ☐ 6/6/24 ☐ Other _____
Mental health and substance abuse limitation	☐ 24-month outpatient ☐ 12-month outpatient ☐ Other _____
Rate Guarantee	☐ 1 Year ☐ 2 Years ☐ Other _____

Additional benefits: Please refer to your proposal for additional benefits available with plan selected. Attach additional signed and dated sheets (reorder UT-52336), if necessary.

Cost of living adjustment (3%)	☐ No ☐ Yes If Yes, ■ lesser of 3% or 1/2 CPI, select number of adjustments ☐ 5 ☐ 10
Activities of daily living	☐ No ☐ Yes If Yes, select additional maximum amount ☐ 10% ☐ 20% ☐ 30% ☐ 40%
Business income protection	☐ No ☐ Yes If Yes, ■ 25% to $5,000
Special conditions limitiation	☐ No ☐ Yes If Yes, ■ 24 months
Survivor income benefit	☐ 3-month gross lump sum ☐ 6-month gross lump sum

e. WORKPLACE VOLUNTARY BENEFITS (all group sizes)

DISABILITY INCOME PLUS ☐ No ☐ Yes **Plan design** ☐ Benefits are provided in conjunction with an 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 ☐ Takeover
☐ Mental, nervous, alcohol and drug abuse ☐ Portability
☐ 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 ☐ ICU/CCU

☐ Disability Income Advantage
Base Benefit period (select all that apply) ☐ 3 Month ☐ 6 Month ☐ 1 Year ☐ 2 Year ☐ 3 Year
Elimination 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 ☐ Takeover
☐ COBRA ☐ Limited mental health/Emotional disease
(only available with EP 0/14, 14/14, or 30/30)

☐ Income Protector (Non-Occ)
Elimination period (select all that apply) ☐ 0/7 ☐ 7/7 ☐ 0/14 ☐ 14/14 ☐ 30/30 ☐ 90/90 ☐ 180/180
Benefit Period (select all that apply) ☐ 90 Day ☐ 6 Month ☐ 1 Year ☐ 2 Year
Optional Riders ☐ Emergency Accident ☐ Outpatient Sickness ☐ Hospital Indemnity

ACCIDENT ☐ Group ☐ Trust ☐ Individual **Base Plan** ☐ Level 1 ☐ Level 2 ☐ Level 3 ☐ Level 4
☐ Benefits will be offered in conjunction with an IRS-qualified pre-tax plan

Optional Riders (May not be available with all plans.)
☐ Hospital Intensive Care (per day) ☐ $150 ☐ $300 ☐ $450 ☐ $600 ☐ $900
☐ Fracture and dislocation ☐ $750 ☐ $1,500
☐ Accident total disability (elimination period) ☐ 1 Day ☐ 7 Days ☐ 14 Days ☐ 30 Days
☐ On-the-job coverage ☐ Travel/Lodging ☐ Loss of work

e. WORKPLACE VOLUNTARY BENEFITS (continued)

CRITICAL ILLNESS ☐ No ☐ Yes **Plan design** ☐ Benefits are provided in conjunction with an HSA plan
☐ Benefits will be offered in conjunction with an IRS-qualified pre-tax plan

Coverage choices ☐ Vascular ☐ Cancer ☐ Other critical illnesses 50 or 100% of face amount

Optional Benefits - Employer Selectable ☐ Benefit recurrence ☐ Loss of work ☐ Takeover

Optional Benefits - Employee Selectable ☐ Health screening benefit $_____ ☐ Automatic benefit increase

CANCER ☐ Cancer Expense ☐ Group Lump Sum Cancer
☐ Benefits will be offered in conjunction with an IRS-qualified pre-tax plan
Optional Riders - Cancer Expense ☐ Hospital indemnity ☐ Lump sum first diagnosis
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 $_____
☐ Automatic benefit increase

SUPPLEMENTAL HEALTH ☐ No ☐ Yes ☐ Benefits will be offered in conjunction with an IRS-qualified pre-tax plan

	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				
☐ ICU/CCU/Burn Unit benefit	$100/day	$200/day	$600/day	$1,000/day

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

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

The companies listed on this Employer Group Application (EGA), severally or collectively as the context may require, are referred to in this EGA as we, us, and our.

In accordance with Section 503 of ERISA, as claims administrator we have authority to make decisions consistent with the terms of the Policy or Certificate regarding (1) eligibility for coverage; (2) paying claims for benefits; (3) interpretation of Policy or Certificate provisions; and (4) resolution of factual questions relating to coverage and benefits.

You, the participating employer, policyholder, contractholder, or Certificate sponsor, intend to establish, sponsor, plan 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.

7. THE FOLLOWING APPLIES TO ALL COMPANIES AND PLANS

You agree to make available your records which we determine are relevant to this EGA and group coverage for inspection by the Trustee, Administrator, us, or our representative during your normal business hours.

If you fail to pay premium when due, coverage may be subject to termination as specified under the terms of the Policy or Certificate. 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. You will receive advance written notice.

For you to remain eligible for the Policy or Certificate, the eligibility, underwriting, participation, and contribution requirements must be maintained, for each respective coverage.

Failure to maintain the plan eligibility, underwriting, participation and contribution requirements will terminate your coverage under the Policy or Certificate.

We have the right to use information provided by you and any employee, dependent or individual to determine whether this EGA will be accepted or declined and to establish appropriate premiums. We will not use any health-related information to decline coverage to an employee, dependent or individual if this EGA is accepted. We will administer this in a non-discriminatory manner.

8. 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 policy/certificate provides limited benefits. Review your policy/certificate carefully.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.

A person that knowingly presents false information in an application for insurance or a viatical settlement is guilty of a crime and may be subject to fines and confinement in prison.

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: _____ (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/BROKER/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/HAN	Tax ID/Social Security Number/HAN
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**
Name (print or type)	Name (print or type)
Social Security Number/HAN	Social Security Number/HAN
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/HAN		
Address	City	State	ZIP code

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:_____

Kanawha Insurance Company, 210 S. White Street, Lancaster, SC 29720

Employer Application

HUMANA
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.

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