ABOUT THE GROUP

Requested Effective Date		
Group Legal Name: (Name on ID cards)	**Group Name:** (DBA)	
Federal Tax ID:	**SIC Code/Nature of Business:**	
Street Address:(No PO Boxes)		
City:	State:	Zip Code:
County:	Phone Number:	
Billing Address:		
City:	State:	Zip Code:
Benefit Administrator:	**Billing Contact:**	
Phone Number:	Phone Number:	
Email Address:	Email Address	

Current or previous Humana coverage:

☐ No

☐ Yes, no longer active Group number:_____ Term date:_____

☐ Yes, currently active* Group number:_____

Active LOC: ☐ Medical ☐ Dental ☐ Vision ☐ Life ☐ Disability

*The group's current renewal date may impact the availability of the requested effective date for new lines of coverage.

Employee Counts

Average Total Number of Employees:	Eligible:

Retiree Information

Minimum age:	Years of service:	Number enrolled in each offered line of coverage: Medical Dental Vision

Additional Group Set-Up Information

Weekly hours worked each week for eligibility:

Probationary Waiting Period: ☐ 0 days ☐ 30 days ☐ 60 days ☐ 90 days ☐ Other:

Effective date of provision: ☐ Immediate ☐ First of the month

Any employees excluded from coverage:

☐No

☐Yes – choose only one: ☐Management ☐Non-management ☐Hourly ☐Salaried ☐Union ☐Non-union

Number of employees eligible in covered class:

Domestic Partner Coverage: ☐Yes ☐No	Affiliates or subsidiaries: ☐Yes* ☐No *Must provide names and counts separately

Automated Clearing House (ACH)	Financial Institution Name:		
Account Name:	Routing Number:		Account Number:
Street Address:	City	State:	Zip Code:
☐ Recurring Payment Schedule Amount: $	Day (1st -10th):		Invoice Format: ☐ Paper ☐ Electronic

COBRA/State Continuation Is this group subject to ☐ Cobra ☐ State Continuation

Name of Applicant	Qualifying Event	Qualifying Event Date	Start Date	End Date	Lines of Coverage

We can count this up once the census is received.

Dental	Enrolled: Waiving w/ other coverage: Waiving w/ no other coverage:	
Existing ☐	Keep as is ☐ Change ☐ Terminate ☐	Alternate Quote Number:
New ☐	Electing ☐ Not Electing ☐	New Business Quote Number:
Plan Selection	Plan 1 Name:	Reference #:
	Plan 2 Name:	Reference #:
	Plan 3 Name:	Reference #:

This section is for new coverage with Humana:

Is the group transferring coverage from another carrier? Yes ☐ No ☐

Does the coverage include orthodontia? Yes ☐ No ☐

Name of prior carrier: _____ Policy Number: _____ Termination Date: _____

Copy of prior carrier statement available to upload: Yes ☐ No ☐

Vision	Enrolled: Waiving w/ other coverage: Waiving w/ no other coverage:	
Existing ☐	Keep as is ☐ Change ☐ Terminate ☐	Alternate Quote Number:
New ☐	Electing ☐ Not Electing ☐	New Business Quote Number:
Plan Selection	Plan 1 Name:	Reference #:
	Plan 2 Name:	Reference #:

Life	Grandfathered Plan: Yes ☐ No ☐	Is the group transferring coverage from another carrier? Yes ☐ Prior Carrier: Termination Date: No ☐
Basic: Electing ☐ Not Electing ☐ AD&D: Electing ☐ Not Electing ☐		Contribution: %
		Plan: Reference #:
		Dependent Life: ☐ Electing ☐ Not Electing ☐ $20,000/$10,000 ☐ $10,000/$10,000 ☐ $10,000/$2,500 ☐ $20,000/$5,000 ☐ $10,000/$5,000 ☐ $5,000/$1,000
Voluntary: Electing ☐ Not Electing ☐ AD&D: Electing ☐ Not Electing ☐		Plan: Reference #:
		Dependent Life: ☐ Electing ☐ Not Electing ☐ $5,000 ☐ $10,000

Short-Term Disability (STD)	Electing Not Electing	Eligible Count: Enrolled Count:
Hours worked to be eligible:	Is the group transferring coverage from another carrier? Yes No Prior Carrier:	Termination Date:

Copy of prior carrier statement available to upload: Yes No
*Statement must include members enrolled and volume amounts.

Class 1		Class 1 Employer Contribution	
Class 2		Class 2 Employer Contribution	
Class 3		Class 3 Employer Contribution	
Class 4		Class 4 Employer Contribution	
Class 5		Class 5 Employer Contribution	

W-2 Services Option – Choose One: Prepare and file W-2 forms Applicant waives W-2 forms services

Long-Term Disability (LTD)	Electing Not Electing	Eligible Count: Enrolled Count:
Hours worked to be eligible:	Is the group transferring coverage from another carrier? Yes No Prior Carrier:	Termination Date:

Copy of prior carrier statement available to upload: Yes No
*Statement must include members enrolled and volume amounts.

Class 1		Class 1 Employer Contribution	
Class 2		Class 2 Employer Contribution	
Class 3		Class 3 Employer Contribution	
Class 4		Class 4 Employer Contribution	
Class 5		Class 5 Employer Contribution	

W-2 Services Option – Choose One: Prepare and file W-2 forms Applicant waives W-2 forms services

Additional Information	
General Agency Name:	**Humana Agent Number:**
Writing Agency Name:	**Humana Agent Number:**
Writing Agent Name:	**Humana Agent Number:**
Group Signatory Name	**Email Address:**
Agent Signatory Name:	**Email Address:**
Addt'l Commn:	**Email Address:**

Please type in the first and last name along with email address for each contact.
GROUP & AGENT are both required. These are the two individuals that will be setup on the Electronic Group Application to E-Sign the paperwork.

The addt'l comm'n field is if there is someone who would like to be looped in on the completion of the forms.