Notice of Privacy Practices

for your *personal* health and financial information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The privacy of your personal and health information is important. You don't need to do anything unless you have a request or complaint.

Relationships are built on trust. One of the most important elements of trust is respect for an individual's privacy. We at Humana value our relationship with you, and we take your personal privacy seriously.

This notice explains Humana's privacy practices, our legal responsibilities, and your rights concerning your personal and health information. We follow the privacy practices described in this notice and will notify you of any changes.

We reserve the right to change our privacy practices and the terms of this notice at any time, as allowed by law. This includes the right to make changes in our privacy practices and the revised terms of our notice effective for all personal and health information we maintain. This includes information we created or received before we made the changes. When we make a significant change in our privacy practices, we will change this notice and send the notice to our health plan subscribers.

What is personal and health information?

Personal and health information - from now on referred to as "information" - includes both medical information and individually identifiable information, like your name, address, telephone number, or Social Security number. The term "information" in this notice includes any personal and health information created or received by a healthcare provider or health plan that relates to your physical or mental health or condition, providing healthcare to you, or the payment for such healthcare.

How does Humana protect my information?

In keeping with federal and state laws and our own policy, Humana has a responsibility to protect the privacy of your information. We have safeguards in place to protect your information in various ways including:

- Limiting who may see your information
- Limiting how we use or disclose your information
- Informing you of our legal duties about your information
- Training our associates about company privacy policies and procedures

How does Humana use and disclose my information?

We must use and disclose your information:
- To you or someone who has the legal right to act on your behalf
- To the Secretary of the Department of Health and Human Services
- Where required by law.

We have the right to use and disclose your information:
- To a doctor, a hospital, or other healthcare provider so you can receive medical care
- For payment activities, including claims payment for covered services provided to you by healthcare providers and for health plan premium payments
- For healthcare operation activities including processing your enrollment, responding to your inquiries and requests for services, coordinating your care, resolving disputes, conducting medical management, improving quality, reviewing the competence of healthcare professionals, and determining premiums
- For performing underwriting activities
- To your plan sponsor to permit them to perform plan administration functions
- To contact you with information about health-related benefits and services, appointment reminders, or about treatment alternatives that may be of interest to you

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- To your family and friends if you are unavailable to communicate, such as in an emergency
- To provide payment information to the subscriber for Internal Revenue Service substantiation
- To public health agencies if we believe there is a serious health or safety threat
- To appropriate authorities when there are issues about abuse, neglect, or domestic violence
- In response to a court or administrative order, subpoena, discovery request, or other lawful process
- For law enforcement purposes, to military authorities and as otherwise required by law
- To assist in disaster relief efforts
- For compliance programs and health oversight activities
- To fulfill Humana's obligations under any workers' compensation law or contract
- To avert a serious and imminent threat to your health or safety or the health or safety of others
- For research purposes in limited circumstances
- For procurement, banking, or transplantation of organs, eyes, or tissue
- To a coroner, medical examiner, or funeral director.

Will Humana use my information for purposes not described in this notice?

In all situations other than described in this notice, Humana will request your written permission before using or disclosing your information. You may revoke your permission at any time by notifying us in writing. We will not use or disclose your information for any reason not described in this notice without your permission.

What does Humana do with my information when I am no longer a Humana member or I do not obtain coverage through Humana?

Your information may continue to be used for purposes described in this notice when your membership is terminated or you do not obtain coverage through Humana. After the required legal retention period, we destroy the information following strict procedures to maintain the confidentiality.

What are my rights concerning my information?

The following are your rights with respect to your information:

- Access – You have the right to review and obtain a copy of your information that may be used to make decisions about you, such as claims and case or medical management records. You also may receive a summary of this health information. If you request copies, we may charge you a fee for each page, a per hour charge for staff time to locate and copy your information, and postage.
- Alternate Communications – You have the right to receive confidential communications of information in a different manner or at a different place to avoid a lifethreatening situation. We will accommodate your request if it is reasonable.
- Amendment – You have the right to request an amendment of information we maintain about you if you believe the information is wrong or incomplete. We may deny your request if we did not create the information, we do not maintain the information, or the information is correct and complete. If we deny your request, we will give you a written explanation of the denial.
- Disclosure – You have the right to receive a listing of instances in which we or our business associates have disclosed your information for purposes other than treatment, payment, health plan operations, and certain other activities. Effective April 1, 2003 or whenever you became a Humana member, Humana began maintaining these types of disclosures and will maintain this information for a period of six years. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.
- Notice – You have the right to receive a written copy of this notice any time you request.
- Restriction – You have the right to ask to restrict uses or disclosures of your information. We are not required to agree to these restrictions, but if we do, we will abide by our agreement. You also have the right to agree to or terminate a previously submitted restriction.

How do I exercise my rights or obtain a copy of this notice?

All of your privacy rights can be exercised by obtaining the applicable privacy rights request forms. You may obtain any of the forms by:

- Contacting us at 1-866-861-2762 at any time
- Accessing our Website at **Humana.com** and going to the Privacy Practices link
- E-mailing us at privacyoffice@humana.com.

Send completed request form to:
Humana Privacy Office
P.O. Box 1438
Louisville, KY 40202

What should I do if I believe my privacy has been violated?

If you believe your privacy has been violated in any way, you may file a complaint with Humana by calling us at 1-866-861-2762 anytime.

You may also submit a written complaint to the U.S. Department of Health and Human Services, Office of Civil Rights (OCR). We will give you the appropriate OCR regional address on request. You also have the option to e-mail your complaint to OCRComplaint@hhs.gov. We support your right to protect the privacy of your personal and health information. We will not retaliate in any way if you elect to file a complaint with us or with the U.S. Department of Health and Human Services.

PRIVACY NOTICE CONCERNING FINANCIAL INFORMATION

Humana and our affiliates understand that the privacy of your personal information is important to you. We take your privacy seriously and your trust in our ability to protect your private information is very important to us. This notice describes our policy regarding the confidentiality and disclosure of personal financial information.

How does Humana collect information about me?

We collect information about you and your family when you complete applications and forms. We also collect information from your dealings with us, our affiliates, or others. For example, we may receive information about you from participants in the healthcare system, such as your doctor or hospital, as well as from employers or plan administrators, credit bureaus, and the Medical Information Bureau.

What information does Humana receive about me?

The information we receive may include such items as your name, address, telephone number, date of birth, Social Security number, premium payment history, and your activity on our Website. This also includes information regarding your medical benefit plan, your health benefits, and health risk assessments.

Where will Humana disclose my information?

We may share your information with affiliated companies and non-affiliated third parties, as permitted by law. We may also provide your information to other financial institutions with which we have joint marketing agreements in order to provide you with offers for products and services you may find of value or which are health-related.

What can I prevent with an opt-out disclosure?

You can prevent the disclosures to non-affiliated third parties that provide products and services not offered by Humana or where the non-affiliated company provides services related to your plan by requesting to opt-out of such disclosures. Your opt-out request will apply to all members or individuals covered under your Humana identification number or member account.

Your opt-out request will continue to apply until you revoke your request or terminate your membership.

How do I request an opt-out?

At any time you can tell Humana not to share any of your personal information with affiliated companies that provide offers of non-Humana products or services. If you wish to exercise your opt-out option, or to revoke a previous opt out request, you need to provide the following information to process your request: your name, date of birth, and your Humana member identification number. You can use any of the methods below to request or revoke your opt-out:

- Call us at 1-866-861-2762
- E-mail us at privacyoffice@humana.com

Notice of Privacy Practices *(continued)*

- Send your opt-out request to us in writing:
  Humana Privacy Office
  P.O. Box 1438
  Louisville, KY 40202

Humana follows all federal and state laws, rules, and regulations addressing the protection of personal and health information. In situations when federal and state laws, rules, and regulations conflict, Humana follows the law, rule, or regulation which provides greater protection.

The following affiliates and subsidiaries also adhere to Humana's privacy policies and procedures:

American Dental Providers of Arkansas, Inc.
American Dental Plan of North Carolina, Inc.
CHA HMO, Inc.
CarePlus
CarePlus Health Plans, Inc.
CompBenefits
CompBenefits Company
CompBenefits Dental, Inc.
CompBenefits Insurance Company
CompBenefits of Alabama, Inc.
CompBenefits of Georgia, Inc.
CorpHealth
CorpHealth Inc.
CorpHealth Provider Link, Inc.
DentiCare, Inc.
Emphesys Insurance Company
Humana Dental Insurance Company
Humana Health Benefit Plan of Louisiana, Inc.
Humana Employers Health Plan of Georgia, Inc.
Humana Health Insurance Company of Florida, Inc.
Humana Health Plan of Ohio, Inc.
Humana Health Plan of Texas, Inc.
Humana Health Plan, Inc.
Humana Health Plans of Puerto Rico, Inc.
Humana Insurance Company
Humana Insurance Company of Kentucky
Humana Insurance Company of New York
Humana Insurance of Puerto Rico, Inc.
Humana Medical Plan, Inc.
Humana MarketPOINT, Inc.*
Humana Medical Plan of Utah
Humana Wisconsin Health Organization
  Insurance Corporation
Kanawha Insurance Company*
Managed Care Indemnity, Inc.*
The Dental Concern, Inc.
The Dental Concern, Ltd.

* These affiliates and subsidiaries are only covered by the Privacy Notice Concerning Financial Information section.

HUMANA®
Guidance when you need it most

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Internal use only
Group number:

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? ❍ No ❍ Yes

Billing address (if different)

City | State | Zip code | County

Nature of business or SIC number | Date company established

Business status: ❍ Corporation ❍ Partnership ❍ Sole Proprietorship ❍ Other: (explain)

Business phone number | Fax number

Management contact | Administrative contact

Management contact e-mail address

Management contact: Mother's maiden name ______________________________

This will be used to gain access to the Employer Self-Service Center on www.Humana.com.

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? ❍ No ❍ Yes

If yes, check class to exclude: (Options may not be available for all plans. Refer to the Underwriting Requirements for each plan.)

❍ union ❍ non union ❍ hourly ❍ salary ❍ management ❍ non-management

How long must employees wait after hire date to become eligible? ❍ 0 days ❍ 30 days ❍ 60 days
❍ 90 days (groups of 2-50 may not exceed 90 days) ❍ Other, specify:

How many employees are eligible for coverage?

New employee effective date provision: ❍ First of month following waiting period (required for HMO, POS and DHMO plans)
❍ 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? ❍ No ❍ Yes

Are any present or former employees/dependents currently on or eligible to elect COBRA/State Continuation? ❍ No ❍ 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:__________________________ By:____
(month, date, year) (employer signature)

Dated at:__________________________ By:____
(city and state) (title)

Agent/Producer Information

1. Agent/Agency of Record (for commissions and correspondence):	**2. Agent/Agency of Record (for split-commissions):**
Name (print)	Name (print)
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%)	Percentage of sales: ❍ No ❍ Yes If yes, percentage: (total should equal 100%)
1. Writing Agent/Producer:	**2. Writing Agent/Producer:**
Name (print)	Name (print)
Social Security Number	Social Security Number
Commission split: ❍ No ❍ Yes If yes, percentage: (total should equal 100%)	Percentage of sales: ❍ No ❍ 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.

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 the 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.

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 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.

2-99 eligible employees

Humana Small Group Medical

TEXAS
EMPLOYER GROUP APPLICATION

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	❍ No ❍ Yes	❍ No ❍ Yes	❍ No ❍ Yes
Supplemental Accident	❍ No ❍ Yes	❍ No ❍ Yes	❍ No ❍ 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:	❍ No ❍ Yes	❍ No ❍ Yes	❍ No ❍ Yes
Special State Options (not available with Consumer Choice Plans)		**PPO and Classic Products**	**HMO and POS Products**
Invitro Fertilization Benefit	❍ No ❍ Yes	Optional	Optional
Serious Mental Illness Benefit	❍ No ❍ 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	❍ No ❍ 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	Excluded HMO State Mandates
Chemical & Alcohol Dependency	Chemical & Alcohol Dependency
TMJ	Oral Contraceptive Drugs & Devices
Home Health Care	TMJ
Serious Mental Illness	Serious Mental Illness
Invitro	Invitro
Speech & Hearing	

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:

Current Plan 1 current carrier rates: Employee: $______ Spouse: $______ Child(ren): $______ Family: $______	**Current Plan 2 current carrier rates:** Employee: $______ Spouse: $______ Child(ren): $______ Family: $______
Plan design:	Plan design:
Office visit copay:	Office visit copay:
Per confinement copay:	Per confinement copay:
Deductible: • Participating ______ • Non-participating ______	Deductible: • Participating ______ • Non-participating ______
Out-of-pocket: • Participating ______ • Non-participating ______	Out-of-pocket: • Participating ______ • Non-participating ______
Coinsurance stoploss: • Participating ______ • Non-participating ______	Coinsurance stoploss: • Participating ______ • Non-participating ______
Emergency room copay:	Emergency room copay:
Prescription drug benefit:	Prescription drug benefit:
Do you as the employer currently fund any of the plan deductible for the employees? ❍ No ❍ Yes If yes, how much of the deductible do you fund?______	Do you as the employer currently fund any of the plan deductible for the employees? ❍ No ❍ Yes If yes, how much of the deductible do you fund?______
Renewal rates: In the parentheses, please indicate the number of employees enrolled in each tier, if available. Employee ( ): $______ Spouse ( ): $______ Child(ren) ( ): $______ Family ( ): $______	**Renewal rates:** In the parentheses, please indicate the number of employees enrolled in each tier, if available. Employee ( ): $______ Spouse ( ): $______ Child(ren) ( ): $______ Family ( ): $______

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:

Thank you for choosing Humana.

HumanaDental

TEXAS
EMPLOYER GROUP APPLICATION

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:	❍ Apply Deductible ❍ Waive Deductible	❍ Apply Deductible ❍ Waive Deductible
Periodontic/Endodontic Options:	❍ Basic ❍ Major	❍ Basic ❍ Major
Orthodontia Options:	❍ Child Only: Lifetime Orthodontia Maximum $____________________ ❍ Adult And Child: Lifetime Orthodontia Maximum $____________________	
Composite Fillings for Molars:	❍ No ❍ Yes	❍ No ❍ Yes
Implant Coverage:	❍ No ❍ Yes	❍ No ❍ Yes
Out of network reimbursement options:	❍ Maximum allowable fee ❍ In-network fee schedule	❍ Maximum allowable fee ❍ In-network fee schedule
Open Enrollment **(100+ groups only)**:	❍ No ❍ 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:

HumanaLife

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Plan Selection

Basic Employee Life and Accidental Death and Dismemberment

❍ Flat Amount—indicate level: $______________________________

❍ Salary Plan—options are 1x to 7x salary, rounded to the next highest $1,000. Indicate salary level: ________________x Salary

❍ Position Schedule—classifications cannot exceed 2.5 times between each class and 10 times between the lowest and highest class.

Class	Description	Benefit Amount/ Salary Factor
I	______________________________	______________
II	______________________________	______________
III	______________________________	______________
IV	______________________________	______________

Basic Dependent Life: ❍ No ❍ Yes
Available only to employees enrolled for Basic Life.

Voluntary Employee Life: ❍ No ❍ Yes
If yes: AD&D ❍ No ❍ Yes

Voluntary Dependent Life: ❍ No ❍ Yes
Available only to employees enrolled for Voluntary Life.

Portability of coverage:
Groups 2-99: Included
Groups 100+: ❍ No ❍ Yes

Underwriting Requirements

- 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, we will terminate your coverage.

Basic Term Life participation

- Non-contributory plans—100%
- Contributory plans—75%
- 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.

Voluntary Term Life participation

- Five employees or 25%, whichever is greater.

Group Information

How much will you contribute to basic life premium? Employee ____________% Dependent ____________%

Humana Insurance Company

Thank you for choosing Humana.

HumanaVision

GENERIC
EMPLOYER GROUP APPLICATION

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 **(100+ groups only)**:	❍ No ❍ 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 Health Savings Account

EMPLOYER GROUP APPLICATION

HSA selection

Please select the type of HSA you would like to enroll.

NOTE: A fee per account will be charged to the employer if moving from one HSA option to another.

- ❑ Standard HSA Option (HSA with monthly fee, investment account and money market sweep account)
- ❑ Value HSA Option (HSA with no monthly fee, no investment account or money market sweep account)

If selecting the Standard HSA Option, how will monthly HSA administrative fees be paid?

- ❑ Bill to employer (please provide "Employer pays" HSA disclosure form to employees at enrollment)
- ❑ Charge to employees' HSA accounts (please provide "Employee pays" HSA disclosure form to employees at enrollment)
- ❑ Bill half to employer, charge half to employees' HSA accounts (please provide "Employer and employee split fee" HSA disclosure form to employees at enrollment)

Should we perform non-discrimination testing for the Health Savings Account (HSA) benefit plan? ❑ No ❑ Yes

If we perform non-discrimination testing there will be an additional fee of $400 per plan year for this service. This fee covers non-discrimination testing for all spending account plans selected.

Enrollment

Employees are responsible to notify the employer directly if they wish to discontinue contributing to the HSA.

How will employees enroll for the HSA?

- ❑ Paper applications or small group web enrollment - Employer is responsible for collecting employee contribution elections.
- ❑ Web enrollment - Employer must access web reports (register on Humana.com) to obtain employee contribution election information.
- ❑ EDI - Employer is responsible for collecting employee contribution elections.

Contribution

Humana recommends that employer contributions to HSA accounts not exceed 50% of the HDHP deductible. No changes to employer contributions to HSAs may be made until renewal.

Who will make contributions to the HSA?

- ❑ Employee only
- ❑ Employer and Employee

If the employer chose to contribute, will the employer match employee contributions to the HSA?

- ❑ No (Please complete the Employer non-matching contributions for HSA in sub-section **A** below.)
- ❑ Yes (Please complete the Employer matching contributions for HSA in sub-section **B** on the following page.)

A. Employer non-matching contributions for HSA

If the employer will make HSA contributions, please provide the whole dollar annual amounts and frequency.

Product Options	*Contribution*		
Tier 1 - Employee	Single	$	NOTE: For SmartSuite a minimum of $250 Employer contribution per tier is required. The single contribution must be less than or equal to all non-single contributions.
Tier 2 - Employee + Spouse	All non-single	$	
Tier 3 - Employee + Child(ren)			
Tier 4 - Family			

Employer Contribution Frequency:

❑ Monthly Contribution ❑ One Lump Sum Contribution ❑ Other Contribution Frequency: ____________________

B. Employer matching contributions for HSA

Indicate Employer contribution frequency:

❑ Weekly ❑ Bi-weekly ❑ Semi-monthly ❑ Monthly

Indicate method by which employer contribution will be capped (limited):

All matching contributions will be capped at the IRS-defined maximum HSA contribution amount.

❑ Dollar amount by coverage level: Single $ _____________ Non-Single $ _____________

❑ Dollar amount by coverage level and salary range (complete maximum employer contribution amount below)

❑ Dollar amount for all employees $_____________

❑ Percent of HDHP deductible __________%

❑ Percentage of IRS-defined maximum _________%

❑ IRS-defined maximum HSA contribution amount

Indicate method and amounts of employer matching contributions:

❑ Match employer contribution by HDHP plan and deductible

HDHP plan name	Deductible		For every $1 employee contribution, employer will contribute:
	Single	Family	
	$	$	$
	$	$	$
	$	$	$

❑ Match employer contribution by salary range		Plan name:		
Enter 1 to 6 salary ranges per plan	For salary ranges:	For every $1 employee contribution, employer will contribute:	Maximum employer contribution amount	
			Single	Non-Single
Range #1	$ to $	$	$	$
Range #2	$ to $	$	$	$
Range #3	$ to $	$	$	$
Range #4	$ to $	$	$	$
Range #5	$ to $	$	$	$
Range #6	$ to $	$	$	$

❑ Match employer contribution by salary range		Plan name:		
Enter 1 to 6 salary ranges per plan	For salary ranges:	For every $1 employee contribution, employer will contribute:	Maximum employer contribution amount	
			Single	Non-Single
Range #1	$ to $	$	$	$
Range #2	$ to $	$	$	$
Range #3	$ to $	$	$	$
Range #4	$ to $	$	$	$
Range #5	$ to $	$	$	$
Range #6	$ to $	$	$	$

Thank you for choosing Humana.

Humana Spending Account Contacts **EMPLOYER GROUP APPLICATION**

Benefits or Human Resources Contact Name at Plan Sponsor

Humana will provide a Check Register Report and a Claims Register report to the Plan Sponsor on a monthly basis for FSAs and PCAs.

Please indicate how reports are to be sent. ❑ Hard Copy ❑ Secured Electronic Mail

Primary Contact (The person responsible to receive Reports and Personal Health Information)

Name Position/Title

Phone number Fax number

Email address

Subsidiary Information for PCA and FSA Only

Plan administrator (ownership company of sponsor, if any)

Business address

City State Zip code Phone number

Business name (subsidiary, if applying):

Employer federal tax ID number

Business address

City State

Zip code

Phone number

Business name (subsidiary 2, if applying):

Employer federal tax ID number

Business address

City State

Zip code

Phone number

Humana FSA and HSA Contributions

Payroll Cycle

Please circle the appropriate pay dates with spending account deductions for the entire Plan Year on the Payroll Calendar component. The Plan Sponsor will be invoiced for a change in pay cycle contributions occurring within the Plan Year. See FSA/PCA Plan Management Agreement for details.

If you have multiple pay cycles please complete a separate payroll calendar for each pay cycle.

Number of calendars submitted (if applicable)_________________

Contribution Files

Please indicate the method by which payroll contribution files will be provided.

Complete this section if applying for an FSA:

❑ **Electronic** (Must have internet connection and file encryption capability. Additional information will be provided. Recommended for employers with 50+ FSA enrollees.)

You will receive a Humana Electronic Transmission Survey further describing options for sending data electronically.

❑ **Paper**

You will receive instructions further describing how to send information on paper.

Send contribution information only. Contribution funds will be drawn as needed, as specified in the Banking Agreement.

Complete this section if applying for an HSA:

❑ **Electronic** (Must have internet connection and file encryption capability. Additional information will be provided. Recommended for employers with 50+ HSA enrollees.)

You will receive a Humana Electronic Transmission Survey further describing options for sending data electronically.

❑ **Paper**

You will receive instructions further describing how to send contribution information on paper to UMB.

Contribution funds must be sent to UMB for the HSA Account.

Persons to contact at the Client's location regarding contribution files:

Name ________________________________ Phone Number ____________________

E-mail (max 50 characters) ____