

Humana Small Group Medical

Humana Insurance Company
Humana Health Plan of Texas, Inc.

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

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

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

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

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

Consumer Choice Medical Plans

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

Consumer Choice PPO: No Yes

Consumer Choice HMO: No Yes

Consumer Choice POS: No Yes

Plan Selection (continued)

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

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

Excluded PPO State Mandates

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

Excluded HMO State Mandates

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

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

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

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

Group Representative Signature: _____

Title: _____ Date Signed: _____

Underwriting Requirements

- You may not sponsor a medical plan from a carrier other than Humana.
- Medical coverage is available to employers with two or more enrolled employees.
- If the only employees of a two-life group are husband and wife, each must enroll separately as an employee and maintain eligibility. The group is only eligible if a bona fide business entity exists.
- Minimum employer contribution toward employee premium is 50%.

- Retirees of a small employer are not eligible for retiree coverage.
- There are no excluded class options for small group medical coverage.
- If you do not maintain eligibility, underwriting, and participation requirements, we will terminate your coverage.

Participation

- All plans – 75%

Group Information

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

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

Company Name	Total Employees

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

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

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

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

Group Information (continued)

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

Date of renewal:

<p>Current Plan 1 Current carrier rates:</p> <p>Employee: \$ _____ Spouse: \$ _____ Child(ren): \$ _____ Family: \$ _____</p> <hr/> <p>Plan design: _____</p> <hr/> <p>Office visit copay: _____</p> <hr/> <p>Per confinement copay: _____</p> <hr/> <p>Deductible: • Participating _____ • Non-participating _____</p> <hr/> <p>Out-of-pocket: • Participating _____ • Non-participating _____</p> <hr/> <p>Coinsurance stoploss: • Participating _____ • Non-participating _____</p> <hr/> <p>Emergency room copay: _____</p> <hr/> <p>Prescription drug benefit: _____</p> <hr/> <p>Renewal rates: In the parentheses, please indicate the number of employees enrolled in each tier, if available.</p> <p>Employee (): \$ _____ Spouse (): \$ _____ Child(ren) (): \$ _____ Family (): \$ _____</p>	<p>Current Plan 2 Current carrier rates:</p> <p>Employee: \$ _____ Spouse: \$ _____ Child(ren): \$ _____ Family: \$ _____</p> <hr/> <p>Plan design: _____</p> <hr/> <p>Office visit copay: _____</p> <hr/> <p>Per confinement copay: _____</p> <hr/> <p>Deductible: • Participating _____ • Non-participating _____</p> <hr/> <p>Out-of-pocket: • Participating _____ • Non-participating _____</p> <hr/> <p>Coinsurance stoploss: • Participating _____ • Non-participating _____</p> <hr/> <p>Emergency room copay: _____</p> <hr/> <p>Prescription drug benefit: _____</p> <hr/> <p>Renewal rates: In the parentheses, please indicate the number of employees enrolled in each tier, if available.</p> <p>Employee (): \$ _____ Spouse (): \$ _____ Child(ren) (): \$ _____ Family (): \$ _____</p>
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1. Has any employee been unable to work 10 or more consecutive days in the past 12 months due to an illness or injury? No Yes
2. Is any employee presently not performing his or her duties on a full-time basis due to an illness or injury? No Yes
3. To the best of your knowledge, is there any employee, individual in a retiree class, dependent (spouse or child), COBRA beneficiary, or individual within their COBRA/State Continuation election period:
 - confined at home, in a hospital, or in a treatment facility;
 - who incurred more than \$10,000 of medical expenses in the past 24 months;
 - who has been advised within the last 90 days to have surgery or be hospitalized;
 - who received treatment, had treatment recommended, or had medication prescribed by a doctor, psychiatrist, psychologist or other licensed practitioner within the past 24 months for any of the following: (check all that apply)
 - AIDS or an AIDS-related complex or other immune system disorder
 - Alcohol or drug abuse or dependence, or psychological disorder
 - Cancer or cancerous tumor
 - Heart or vascular disease or stroke
 - Diabetes or any disease or disorder of the kidneys, liver or lungs
 - Systemic disease including, but not limited to Lupus, Multiple Sclerosis, or Muscular Dystrophy
 - Organ transplant (other than corneal)

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

Question #	Member Status*	Age	Medical Condition/ Diagnosis	Date(s) of Treatment	Medication Name/Dosage	Past/Current/Future Treatment

* Member Status: E=Employee D=Dependent C=COBRA/State Continuation R=Retiree

Has your company, at any time during the past 24 months, had medical coverage terminated or a renewal of medical coverage refused?

No Yes If yes, please explain:

Have any medical benefits now, or within the past 24 months, been funded by you in any manner other than health insurance premium payment? No Yes If yes, please provide details and attach medical claims experience for the applicable time period up to 24 months.

Retiree Information

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