



Georgia Employer Group Application

PRINT OR TYPE ALL SECTIONS IN BLACK INK

HMO and HMO POS plans offered by Humana Employers Health Plan of Georgia, Inc.
PPO and Classic Medical plans, Life and STD plans insured by Humana Insurance Company
Dental plans insured by HumanaDental Insurance Company

Requested Effective Date

Group Number

GROUP INFORMATION

Name of Group		Type of Business	Employer ID #	Phone ()	Fax ()
Location Address (not a P.O. Box)		City	County	State	Zip
Billing/Mailing Address		City		State	Zip
DBA			Workers' Compensation Carrier		
Administrative Contact	E-mail Address	Management Contact	E-mail Address		

MULTILOCATION NO YES (complete Multilocation form)

ELIGIBILITY

Total Number of Employees on Payroll: _____
 Full-time employees working 30 hours or more per week are eligible if employed by YOU. Part-time and seasonal employees are not eligible.
 YOU may choose a different hourly requirement of not less than 20 or more than 40. YOUR hourly requirement: _____
 Total number of employees working the hours YOU indicated or more: _____ Number of Employees Enrolling: _____
 For groups of 51+, classes of eligible employees to be excluded: None Union Non Union Hourly Salary
 New Employee Waiting Period: 0 Days 1 Month 2 Months 3 Months Other, Specify _____
 New Employee Effective Date Provision: First of month following waiting period (Required for Medical HMO and POS)
 Immediately following waiting period
 On all plans, the employee termination date coincides with the effective date provision.
 Do YOU wish to have 24 hour coverage for Owners, Officers, or Partners not covered by Workers' Compensation? NO YES
 Name(s) _____
RETIREE - The retiree class will be considered if YOU have 26 or more employees enrolled for such coverage. Retirees are not eligible for any Life or Disability benefits. Do YOU want Retirees covered for: Medical NO YES Dental NO YES Age _____ Years of Service _____

Will YOUR employees have access to another carrier's Medical and/or Dental coverage by virtue of their employment with YOU? NO YES
 Name of Carrier(s) Medical _____ Dental _____

COBRA - Are any present or former employees/dependents currently on or eligible to elect COBRA/State Continuation? NO YES

Name of Applicant	Qualifying Event (ex: termination of employment, divorce, etc.)	Date of Qualifying Event	Date COBRA or State Continuation coverage terminates
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are there any other entities associated with this company that are eligible to file a combined tax return? NO YES

Company Name _____	Total Employees _____
Company Name _____	Total Employees _____
Company Name _____	Total Employees _____

EMPLOYER CONTRIBUTION (See Participation Requirements)

	MEDICAL	NON-VOLUNTARY DENTAL	VOLUNTARY DENTAL	BASIC LIFE	BASIC DEPENDENT LIFE	VOLUNTARY LIFE	SHORT TERM DISABILITY
EMPLOYER CONTRIBUTION?	Employee % Dependent %	Employee % Dependent %	N/A	%	%	N/A	%
PRIOR GROUP COVERAGE?	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES		N/A	N/A	<input type="checkbox"/> NO <input type="checkbox"/> YES

Do YOU have prior Ortho coverage? NO YES For any prior coverage, submit term date and recent billing statement.

MEDICAL BENEFIT PLAN OPTIONS

PLAN SELECTION - To complete this information refer to YOUR proposal or plan brochure. NOTE: Submit YOUR proposal along with this Application.

	<u>Selection 1</u>	<u>Selection 2</u>	<u>Selection 3</u>
PRODUCT NAME(S) (e.g., Copay 90/70, Classic 80%, Coverage First PPO 80/60 \$25)			
OFFICE VISIT			
COPAYMENT (if applicable) Participating \$			
DEDUCTIBLE (if applicable) Participating \$			
Non-Participating \$			
OUT-OF-POCKET			
LIMIT (if applicable) Participating \$			
Non-Participating \$			
NETWORK NAME (if applicable)			

OPTIONS

	Yes	No	Yes	No	Yes	No
HumanaPPO & Humana Classic						
Deductible Carryover Credit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Supplemental Accident	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prescription Drug - Retail card	Level 1/Level 2/Level 3/Level 4 \$ / \$ / \$ / %	Level 1/Level 2/Level 3/Level 4 \$ / \$ / \$ / %	Level 1/Level 2/Level 3/Level 4 \$ / \$ / \$ / %	Level 1/Level 2/Level 3/Level 4 \$ / \$ / \$ / %	Level 1/Level 2/Level 3/Level 4 \$ / \$ / \$ / %	Level 1/Level 2/Level 3/Level 4 \$ / \$ / \$ / %
HumanaHMO & HMO POS (Plans A, B, C, D)	Yes	No				
Prescription Drug - Retail card						
\$5 generic/\$15 brand/\$30 non-formulary	<input type="checkbox"/>	<input type="checkbox"/>				
\$10 generic/\$20 brand/\$35 non-formulary	<input type="checkbox"/>	<input type="checkbox"/>				
Mental Health	<input type="checkbox"/>	<input type="checkbox"/>				
Vision Plan 1	<input type="checkbox"/>	<input type="checkbox"/>				
Vision Plan 2	<input type="checkbox"/>	<input type="checkbox"/>				
HumanaHMO & HMO POS						
Prescription Drug - Retail card	Level 1/Level 2/Level 3/Level 4 \$ / \$ / \$ / %	Level 1/Level 2/Level 3/Level 4 \$ / \$ / \$ / %	Level 1/Level 2/Level 3/Level 4 \$ / \$ / \$ / %	Level 1/Level 2/Level 3/Level 4 \$ / \$ / \$ / %	Level 1/Level 2/Level 3/Level 4 \$ / \$ / \$ / %	Level 1/Level 2/Level 3/Level 4 \$ / \$ / \$ / %
Humana Coverage First						
Prescription Drug - Retail card	Level 1/Level 2/Level 3/Level 4 \$ / \$ / \$ / %	Level 1/Level 2/Level 3/Level 4 \$ / \$ / \$ / %	Level 1/Level 2/Level 3/Level 4 \$ / \$ / \$ / %	Level 1/Level 2/Level 3/Level 4 \$ / \$ / \$ / %	Level 1/Level 2/Level 3/Level 4 \$ / \$ / \$ / %	Level 1/Level 2/Level 3/Level 4 \$ / \$ / \$ / %

SPECIAL STATE OPTIONS - HumanaPPO & Humana Classic Plans

Mental Disorder Benefit:
Large Employer (51+) Yes No

If enrolling in a SmartSuite product, please indicate plan and option numbers:

Plan: Option: Plan: Option: Plan: Option: Plan: Option: Plan: Option: Plan: Option:

DENTAL BENEFIT PLAN OPTIONS

Is this a SmartSuite selection? No Yes

	PLAN	UCR PERCENTILE	DEDUCTIBLE	ANNUAL MAXIMUM	OPTIONAL ***LIFETIME ORTHODONTIC MAX
TRADITIONAL PREFERRED	<input type="checkbox"/> Gold 185 <input type="checkbox"/> Silver 164 <input type="checkbox"/> Perio/Endo Buy Up Option to Basic.*	_____	<input type="checkbox"/> \$25 <input type="checkbox"/> \$50 <input type="checkbox"/> \$100	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$2,500	10+ Lives Children <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> None Adult**** <input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Bronze 150 Available to groups 10+ lives	N/A	\$50 <input type="checkbox"/> Waive Deductible**	\$1,000	Not available
VOLUNTARY TRADITIONAL PREFERRED	<input type="checkbox"/> Gold 185 <input type="checkbox"/> Silver 164	_____	<input type="checkbox"/> \$25 <input type="checkbox"/> \$50 <input type="checkbox"/> \$100 <input type="checkbox"/> Waive Deductible**	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500	10+ Lives Children <input type="checkbox"/> \$1,000 <input type="checkbox"/> None
	<input type="checkbox"/> Bronze 150 Available to groups 10+ lives	N/A	\$50 <input type="checkbox"/> Waive Deductible**	\$1,000	Not available

*Periodontics and Endodontics covered under Major Services, unless the buy up option to Basic Services is selected.

**Waive Preventive Services deductible on Traditional Preferred Bronze 150 and Voluntary Traditional Preferred Plans (select box if YOUR group chooses this option).

***Lifetime Orthodontic Maximum must be less than or equal to Annual Maximum.

****Adult Ortho option available to groups 25+ lives only when child ortho selected. Same lifetime max. benefit selection is applicable for adult.

LIFE AND DEPENDENT LIFE BENEFITS

Benefits are available only to active full-time employees at work on the effective date of coverage. Active full-time employees age 65 or older receive a reduced amount of their class coverage amount. The employee minimum coverage requirement is \$15,000. The combined Basic and Voluntary Employee Life coverage maximum is the lesser of 6x salary or \$1,000,000.

Basic Employee Life and Accidental Death and Dismemberment

- Level Amount** - Indicate level: \$ _____
 - Salary Plan** - Options are 1x to 6x salary, rounded to next highest \$1,000. Indicate salary level: _____
 - Position Schedule** - Classifications cannot exceed 2 1/2 times between each class and 10 times between the lowest and highest class.
- | Class | Description | Life/AD&D Amount |
|-------|-------------|------------------|
| I | _____ | \$ _____ |
| II | _____ | \$ _____ |
| III | _____ | \$ _____ |
- Options: No AD&D

Voluntary Employee Life/AD&D -

- For groups with 5-50 enrolled employees maximum = \$250,000. For groups with 51+ enrolled employees maximum = \$500,000.
- Yes If yes: AD&D Yes
 - No No
- Portability of Coverage -**
Included for groups size 2-99, optional for groups 100+.
- Yes
 - No

Basic Dependent Life Benefit - Available only if employer has selected Basic Employee Life/AD&D.

- Yes No
- \$10,000/\$5,000 \$5,000/\$2,500

Voluntary Dependent Life Benefit

Available only to employees enrolled for Voluntary Life (AD&D) above.

SHORT TERM DISABILITY BENEFIT

Benefits are available only to active full-time employees at work on the effective date of coverage. Benefits terminate upon attainment of age 70 or retirement, whichever occurs first, unless the employer has 20 or more employees. Minimum weekly coverage amount is \$100. Maximum weekly coverage amount is the lesser of \$500 or 66 2/3% of base weekly salary.

Plan Structure:

- Standard Plan:
Accident: 1st day
Sickness: 8th day
Duration: 26 weeks
- Specify Plan:
Accident: _____ day
Sickness: _____ day
Duration: _____ weeks

Benefit Structure:

- Level Amount** - Indicate weekly amount in \$10 increments: \$ _____
 - Salary Plan** - 50% 60% 66 2/3% Weekly benefit payments will be rounded to the next highest \$10.
 - Position Schedule** - Classifications cannot exceed 2 1/2 times between each class and 10 times between the lowest and highest class.
- | Class | Description | Short Term Disability Amount |
|-------|-------------|------------------------------|
| I | _____ | \$ _____ |
| II | _____ | \$ _____ |
| III | _____ | \$ _____ |

GROUP PROFILE

In accordance with YOUR company records and to the best of YOUR knowledge, answer the following questions:

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. Is there any employee, individual in a retiree class, dependent (spouse or child), COBRA beneficiary, or individual within their COBRA election period:
 - a) confined at home, in a hospital, or in a treatment facility;
 - b) who had more than \$10,000 of medical expenses in the past 24 months;
 - c) who has been advised within the last 90 days to have surgery or be hospitalized;
 - d) 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).

FOR ANY "YES" ANSWERS GIVEN TO QUESTIONS 1-3 IN THE GROUP PROFILE, SUBMIT THE FOLLOWING INFORMATION FOR EACH INDIVIDUAL. IF ADDITIONAL SPACE IS NEEDED, PLEASE USE A SIGNED AND DATED ADDENDUM.

Question Number	*Class of Insured	Age	Medical Condition/Diagnosis	Date(s) of Treatment	Medication Name/Dosage	Past/Current/Future Treatment

*Class: E=Employee; D=Dependent; C=COBRA; R=Retiree Class

4. 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, give details)

5. Have any Medical benefits now, or within the past 24 months, been funded by YOU in any manner other than health insurance premium payments?
 NO YES (If yes, please give details AND submit Medical claims experience for the applicable time period up to 24 months.)

6. The number of different health care carriers YOUR group has had in the last 5 years _____

7. If Medical coverage is requested, provide the current and renewal Medical insurance premium rates below for up to two medical plans and forward a copy of YOUR most recent bill to YOUR local sales office or agent. Please indicate the number of individuals covered in each tier in the renewal rates portion below

Current Rates:

HMO	PPO
Employee: \$ _____ Spouse: \$ _____	Employee: \$ _____ Spouse: \$ _____
Child(ren): \$ _____ Family: \$ _____	Child(ren):\$ _____ Family: \$ _____

Renewal Rates: Date of renewal: _____

HMO	PPO
EE(____) \$ _____ SP(____) \$ _____	EE(____) \$ _____ SP(____) \$ _____
CH(____) \$ _____ FA(____) \$ _____	CH(____) \$ _____ FA(____) \$ _____

(Please indicate the number of employees enrolled in each tier in the bracket provided, if available)

Current Plan:

HMO	PPO
Plan Design: _____	Plan Design: _____
OV Copay: _____	OV Copay: _____
Per Confinement Copay: _____	Per Confinement Copay: _____
Deductible: _____	Deductible: _____
in network: _____ out of network: _____	in network: _____ out of network: _____
Coinsurance Stoploss: _____	Coinsurance Stoploss: _____
in network: _____ out of network: _____	in network: _____ out of network: _____
ER Copay: _____	ER Copay: _____
RX Benefit: _____	RX Benefit: _____

THE FOLLOWING APPLIES TO VOLUNTARY LIFE PORTABILITY PRODUCTS INSURED BY HUMANA INSURANCE COMPANY

YOU, the Participating Employer, apply to participate in the Employers Health Insurance Benefits Trust for insurance coverage, which may be modified from time to time, as underwritten by the insurer (WE, US and OUR): Humana Insurance Company.

If YOU are accepted, YOU acknowledge and agree on behalf of all persons who obtain insurance coverage through or under YOUR Application to the Trust, that the Trust Agreement, under which AmSouth Bank, Birmingham, AL, is named the Trustee, the provisions of the Trust, or any other written instrument the Trustee signs on behalf of the Trust are fully binding upon YOU. The principal duties of the Trustee are to hold the insurance policy(ies) through which insurance coverage is provided for employers in accordance with the terms of the Trust Agreement or any other written instrument which the Trustee signs on behalf of the Trust. The Trust Agreement, any other written instrument and the insurance policy(ies), are available for inspection by YOU or by any covered person through or under YOUR participation in the Trust, during normal business hours at OUR Home Office. YOU further understand and agree that the Trust and Trustee are not insurers.

YOU may withdraw from the Trust at any time subject to certain premium obligations described in the EMPLOYER AGREEMENT section, thus terminating YOUR insurance coverage, provided written notice of termination is received by US prior to the requested termination date. YOU understand that individuals who have ported Voluntary Life Portability can continue their ported Voluntary Life coverage under the Trust even when YOU have terminated the Voluntary Life Portability option.

THE FOLLOWING APPLIES TO ALL PRODUCTS

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 the Employee Retirement Income Security Act of 1974 (ERISA). YOU are the ERISA Plan Administrator.

Small Employer means a person, firm, corporation, partnership or association actively engaged in business, which employed an average of at least 2 but no more than 50 employees on business days during the preceding calendar year and who employs at least 2 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.

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.

With respect to paying claims for benefits or determining eligibility for coverage under this Policy or Group Plan, WE as administrator for claims determinations and as ERISA claims review fiduciary as described in 29 C.F.R. 2560.503-1(g)(2), shall have full and exclusive discretionary authority to: 1) interpret Policy or Group Plan 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 or Group Plan. Except for non-payment of premium or when a group or individual is not or has not been eligible for coverage, YOU will be provided with advance written notice of YOUR termination of coverage according to the termination provisions of the Policy. 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.

For YOU to remain eligible for the Trust, Policy or Group Plan, the eligibility, Underwriting and Participation Requirements must be maintained, for all coverage. Failure to maintain the plan eligibility, Underwriting and Participation Requirements will terminate YOUR coverage under the Policy or Group Plan. Other termination provisions are stated in the Policy or Group Plan.

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 unless permitted by law.

UNDERWRITING AND PARTICIPATION REQUIREMENTS

YOU must have the greater of 2 employee lives or as indicated by coverage. If the only employees of a two-life group are husband and wife, the group will only be eligible if: a bonafide business entity exists; each work the required number of hours per week at the business; each must enroll and maintain eligibility as an employee; dependents may be covered under either employee. Failure to maintain participation requirements will result in termination of that coverage.

MEDICAL

1. If YOU elect this coverage, and you pay 100% of the premium, YOU must have 100% participation of employees eligible for Medical benefits.
2. If YOU pay less than 100% of the premium, YOU must have the greater of 2 employee lives or 75% participation of employees eligible for Medical benefits.
3. YOU are required to contribute at least 50% of the premium for each employee benefit.
4. For groups with less than ten employees, YOU must submit Evidence of Health Status for all employees and dependents. (Will not be used to decline Medical coverage of a small employer.
5. For groups with less than 51 employees YOU may not sponsor a Medical plan from a carrier other than Humana Insurance Company or Humana Employers Health Plan of Georgia, Inc. All Medical coverage may be terminated if YOU offer other Medical coverage from a carrier other than Humana Insurance Company or Humana Employers Health Plan of Georgia, Inc. WE will deem YOU to be offering such coverage if employees have access to another carrier's Medical coverage by virtue of their employment with YOU.

BASIC LIFE/AD&D

1. 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%.
2. Multiple Medical Carrier: If YOU offer more than one Medical carrier, YOU must enroll 100% of those employees who take Humana Insurance Company or Humana coverage regardless of the percentage of contribution paid by YOU.

VOLUNTARY LIFE/AD&D

1. If YOU elect this coverage, YOU must have greater of 5 eligible employees or 25% of eligible employees participating in order to offer Voluntary Life coverage. No employer contribution required.

BASIC DEPENDENT LIFE

1. No employer contribution required.
2. If YOU elect this coverage and pay 100% of the premium, 100% of all employees with dependents must enroll for coverage.
3. If YOU elect this coverage and pay less than 100% of the premium, a minimum of 50% of all employees with dependents must enroll for coverage.

VOLUNTARY DEPENDENT LIFE

1. Available only if the employee has selected Voluntary Life/AD&D. No special participation requirements.

SHORT TERM DISABILITY

1. If YOU elect this coverage, 100% participation required for all eligible employees group size 2-5 and all size non-contributory groups. For contributory plans, group size 6+, 75% participation required. Minimum employer contribution 50%.

DENTAL

YOU may not sponsor a Dental plan from a carrier other than US. All Dental coverage may be terminated if YOU offer other Dental coverage from a carrier other than US. WE will deem YOU to be offering such coverage if employees have access to another carrier's Dental coverage by virtue of their employment with YOU.

Non-Voluntary

1. If YOU elect this coverage and pay 100% of the premium, YOU must have 100% participation of all eligible employees, regardless of whether they have Dental coverage through their spouse.
2. If YOU elect this coverage and YOU pay less than 100% of the premium, YOU must have the following participation of eligible employees:

Eligible Employees:	2 - 4	5 - 9	10+
Participation Requirements:	100%	75%	75% (50% with spousal waiver)

3. YOU are required to contribute at least 25% of the premium for each employee benefit.
4. Groups enrolled with less than 5 eligible employees require Medical coverage.

Voluntary

If YOU elect this coverage, YOU must have the greater of 5 eligible employees or 25% of eligible employees participating, regardless if they have Dental coverage through their spouse. No employer contribution required.

EMPLOYER AGREEMENT

YOU, the employer, understand and agree that 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 the Application. YOU agree to collect any employee contribution toward premium. If this Application is declined, WE will return the premium deposit submitted with the Application. YOU understand and agree that neither YOU nor the agent has the authority to waive a complete answer to any question, pass on coverage, alter any contract, or waive any of OUR other rights or requirements. YOU hereby certify that YOU have read this document and that the information provided is accurate and complete. YOU also certify that the information provided here can be substantiated by business records maintained by YOU. YOU agree to provide the documentation requested by US which establishes that all eligibility, underwriting and participation requirements of the Group Plan are met. YOU understand and agree that only individuals who meet the eligibility requirements of the Group Plan are entitled to maintain coverage. YOU understand that providing incomplete, inaccurate, or untimely information may void, reduce, or terminate an individual's coverage or the group's coverage. This document will form part of any contract issued. Coverage is not in effect unless and until YOU receive written notification from US. **UNDER NO CIRCUMSTANCES SHOULD YOU CANCEL YOUR PRESENT GROUP COVERAGE WITHOUT PRIOR NOTICE OF APPROVAL OF YOUR APPLICATION FOR COVERAGE BY US.**

DATED ON: _____ BY: **X** _____
(Month, Day, Year) (Employer signature)
DATED AT: _____ (City and State) _____ (Title)

AGENT INFORMATION

1. AGENT/AGENCY OF RECORD (Commissions/Correspondence)

Social Security/Tax ID No. _____
Name _____
Street _____
City _____ State _____ Zip _____
Phone No. _____ Fax No. _____
Commission Split _____ % (Required for split commissions, total % should = 100)
WRITING AGENT (Agent who actually solicited the case)
Name _____
Street _____
City _____ State _____ Zip _____
Phone No. _____ Fax No. _____
Social Security Number _____
Agent E-Mail Address _____

2. AGENT/AGENCY OF RECORD (For Split Commissions)

Social Security/Tax ID No. _____
Name _____
Street _____
City _____ State _____ Zip _____
Phone No. _____ Fax No. _____
Commission Split _____ % (Required for split commissions, total % should = 100)

As the Writing Agent, 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 products and services of the offering entity, Humana, or one of its subsidiaries. These provisions are available to me and the Employer in the Regulatory and Technical Information Guide or other Humana marketing material.

Writing Agent's Signature _____
Date _____