

HUMANA NEW BUSINESS ENROLLMENT REQUIREMENTS

(This form does not include any State specific requirements)

In order to expedite the processing of your applications; please be sure all the following applicable information is complete.

Under no circumstances should the Employer cancel their present coverage without prior notice of approval by us.

For current Employer and Employee applications, please refer to our website at www.humana.com, or contact your sales representative.

Company Name

FORMS NEEDED FOR CASE SUBMISSION

(Please check that each item is present)

Employer Group Application	
Employee Enrollment Forms – should be completed for every full time employee, including those waiving coverage.	
First Month Premium Check - Written on company check - Made payable to Humana	
Copy of Sold Quote	
Most Recent Quarterly State Wage & Tax Report If person on report is not full-time, indicate the status (termed, part-time, etc.).	

Eligibility Certification Form – Should be completed for employees not appearing on the State Wage and Tax.	
Prior Carrier Bill - Most recent statement showing all the covered employees - Name, address, phone number and policy number of prior carrier - Termination date with the prior carrier - Coverage types (EE, ES, EC, FA) with prior carrier	
Multi-Location Humana Multiple Location Form List of employees by location	

EMPLOYER GROUP APPLICATION (EGA)

Name of Employer/Type of Business/Phone Number/Fax Number	
Employer ID (if applicable)	
Location Address	
Billing/Mailing Address – if different than the location address	
Doing Business as Name (if applicable)	
Worker's Compensation Carrier's Name (if applicable)	
Administrative and Management Contact	
Multi-location (No or Yes) – If yes, submit multi-location form.	
Total Employees on Payroll/Number of Employees Enrolling	
Hourly Requirement (if applicable)	
Waiting Period and Effective Provision	
24 Hour Coverage (No or Yes) – If yes, provide names and titles.	
Retiree Information (if applicable)	
COBRA/State Continuation – indicate the employees, qualifying event, date of that event, and end date of the coverage.	

Other Entities (No or Yes) – If yes, list company name and total employees.	
Employer Contribution Percentages	
Prior Employer Coverage (No or Yes) – If yes, submit prior carrier bill.	
Medical Benefit Plan Options – include the product, deductible, coinsurance, out of pocket, network, and options	
Dental Benefit Plan Options - include the product, UCR, deductible, annual maximum and orthodontia	
Basic Life and/or Dependent Life – include plan options and amounts	
Voluntary Life/AD&D (Yes or No)	
Short Term Disability	
Group Profile – In states where applicable.	
Employer Agreement – include dated on, dated at, city, state, and title (Signed by owner, officer, or partner)	
Agent Information – complete all information including date, agent signature, and agent license number.	

HUMANA NEW BUSINESS ENROLLMENT REQUIREMENTS (CONTINUED)

EMPLOYEE APPLICATION

Employer Information – include working location of Employee	
Employee Information – complete entire section	
Dependent Information – complete entire section	
Plan Selections for Medical and/or Dental – (EE, ES, EC, FA)	
Short Term Disability Coverage (Yes or No) If yes, include amount/class.	
Basic Life/AD&D – If Basic Life elected, include amount, class, and beneficiary name(s).	
Basic Dependent Life – If elected, list dependents in the dependent information section.	
Voluntary Employee Life/AD&D - (Yes or No) If yes, include amount and beneficiary name(s).	
Voluntary Dependent Spouse Life/AD&D – (Yes or No) If yes, include amount and list spouse in the dependent information section.	
Voluntary Dependent Child(ren) Life - (Yes or No) If yes, list children in dependent information section.	
Hours per Week	

Employee or Dependent Disabled Question (No or Yes) – If yes, list name, date, reason and submit a disability questionnaire if applying for Medical or Life coverage.	
Medicare question – (No or Yes) If yes, list name, date, reason and type of coverage.	
Prior Carrier Information – Medical (No or Yes) – If yes, complete all lines.	
Prior Carrier Information – Dental (No or Yes) – If yes, complete all lines.	
Waiver Section – check box of any coverage being waived and the reason for waiving. Employee date and sign.	
Acknowledgment/Agreement of Coverage Employee date and sign.	
Evidence of Health Status If required, answer all questions Yes or No with details provided for Yes responses.	
Agreement – Employee date and sign. Spouse date and sign if applying for coverage.	