Employer Enrollment Form

Humana®

KENTUCKY Humana.com

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in this Employer Enrollment Form as "Humana", "We", "Us", or "Our".
• **Humana Health Plan, Inc.**, 321 West Main Street, Louisville, KY 40202 • **Humana Insurance Company of Kentucky**, 500 West Main Street, Louisville, KY 40202 • **The Dental Concern, Inc.**, 500 West Main Street, Louisville, KY 40202

For PPO, HMO, or POS Medical plans, coverage is provided by Humana Health Plan, Inc., a Health Maintenance Organization. For Indemnity Medical plans, insurance coverage is provided or administered by Humana Insurance Company of Kentucky. For Dental, insurance coverage is provided or administered by The Dental Concern, Inc. Vision plans insured or administered by The Dental Concern, Inc.

1. EMPLOYER INFORMATION – Please type or print clearly in black ink

Association Name and Group number: KY Assoc Builders & Contr 28300

Employer name:				Requested effective date __/__/____
Situs location street address:	City:	State:	ZIP code:	County:
Date company established (MM/DD/YYYY):	Federal Tax ID:	Nature of business/SIC code:	Phone number:	
Benefit Administrator/management contact name:				
Phone number:	Email address:			
Billing contact name:				
Billing address (N/A if same as street address):	City:	State:	ZIP code:	
Phone number:	Email address:			

Are separate divisions/classes required for billing or reporting? ☑ No ☐ Yes
If yes, please explain. Attach additional signed and dated sheets, if necessary.

2. ELIGIBILITY REQUIREMENTS

Average total number of employees ☐	This means the average number of employees for the preceding calendar year. An employee is typically any person for which the company issues a W-2, regardless of full-time, part-time or seasonal status or whether or not they have medical coverage.
Average number of full-time equivalent employees ☐	For all employees included in the average total number of employees (above), calculate the average number of full-time equivalents for the preceding calendar year. The monthly full-time equivalents are calculated as follows: • number of **full-time employees** (who worked 30 hours or more per week on average); plus • total number of hours worked by **part-time employees** during the month capped at 120 hours, divided by 120.

Eligible employee count (including those employees who waive coverage):	**Medical**	**Dental**	**Vision**

Are you offering coverage to retirees (Non-Community Rated Medical, Dental and Vision)? ☑ No ☐ Yes
Required age (minimum 50): Minimum years of service:

Number of retirees to be covered:	**Medical:** 0	**Dental:** 0	**Vision:** 0

Does this company have any subsidiaries or affiliates, or are there any other associated entities that are eligible to file a federal or state combined tax return? ☐ No ☐ Yes If yes, enter information below:

Company name	**Total employees**

Probationary waiting period for eligible employees: ☐ 0 days ☐ 30 days ☐ 60 days ☑ 90 days ☐ Other: _____
If you prefer months, please select "Other" and specify the number of months.
Medical probationary waiting period must not exceed 90 days. HMO plans requiring referrals must not exceed 60 days.

Employee effective provision (the employee termination date coincides with the effective date provision):
☐ First of the month following probationary waiting period (required for HMO plans requiring referrals)
☑ Immediately following probationary waiting period (required for 90 day probationary waiting period)

Do you want to exclude a class of employees? ☐ No ☐ Yes
If yes, check class to exclude:
☐ Union ☐ Non-union ☐ Hourly ☐ Salary ☐ Management ☐ Non-management ☐ Other:

Is this a Collectively Bargained Plan? ☐ No ☐ Yes Name of plan _____
Plan number (assigned by employer for use in filing IRS form 5500):

Has this group been insured by Humana within the last three years? ☐ No ☐ Yes
If yes, provide prior group number: Termination date:

Do you wish to offer Domestic Partner coverage? ☐ No ☐ Yes

3. COBRA/STATE CONTINUATION

Is your group subject to: COBRA ☐ No ☐ Yes State Continuation ☐ No ☐ Yes

Are any present or former employees/dependent currently on or eligible to elect COBRA/State Continuation? ☐ No ☐ Yes
If yes, enter information below. Attach additional signed and dated sheets (reorder KY-52660), if necessary.

Name of applicant	Qualifying event (e.g. termination of employment, divorce, etc)	Indicate if the applicant is currently on COBRA or State Continuation	COBRA/State Continuation			Lines of coverage (select all that apply)		
			Qualifying event date	Start date	End date	Medical	Dental	Vision
		☐ COBRA ☐ State Continuation				☐	☐	☐
		☐ COBRA ☐ State Continuation				☐	☐	☐
		☐ COBRA ☐ State Continuation				☐	☐	☐
		☐ COBRA ☐ State Continuation				☐	☐	☐

Plan Selection – Please review the Regulatory Pre-enrollment Disclosure Guide with your agent, broker or producer. Complete the quote number and reference number (if applicable) to indicate the plans elected.

4. MEDICAL PLAN SELECTION ☐ Electing ☐ Not electing **Humana Health Plan, Inc.**, 321 West Main Street, Louisville, KY 40202

• **Humana Insurance Company of Kentucky**, 500 West Main Street, Louisville, KY 40202

Sold quote number: _____
Plan 1 name _____ / Reference # _____
Plan 2 name _____ / Reference # _____
Plan 3 name _____ / Reference # _____
Plan 4 name _____ / Reference # _____

5. DENTAL PLAN SELECTION ☐ Electing ☐ Not electing **The Dental Concern, Inc.**, 500 West Main Street, Louisville, KY 40202

Sold quote number: _____
Plan 1 name _____ / Reference # _____
Plan 2 name _____ / Reference # _____
Plan 3 name _____ / Reference # _____
Attach additional signed and dated sheets (reorder KY-52659), if necessary.

6. VISION PLAN SELECTION ☐ Electing ☐ Not electing **The Dental Concern, Inc.**, 500 West Main Street, Louisville, KY 40202

Sold quote number: NOT AVAILABLE
Plan 1 name _____ / Reference # _____
Plan 2 name _____ / Reference # _____
Dual choice arrangements are subject to underwriting review.

7. AGREEMENT AND SIGNATURE

I, an authorized representative of the Employer, understand, agree and represent:

1. The Employer is eligible for coverage under the Policy because (a) the Employer is a member in good standing of a group or association of employers that is the Policyholder, (b) the Employer is within an approved SIC code range provided on the Humana proposal issued to the Policyholder, (c) the Employer is a bona fide business entity, and (d) the Employer employs at least two common-law employees. To remain eligible, the Employer must meet these requirements for each respective coverage at all times.

2. If the group or association of employers is no longer an employer within the meaning of section 3(5) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), 29 U.S.C. § 1002(5) or if the total number of employees of all employers within the group or association that are eligible to participate in the Policy is less than 51 employees, the Employer will not be eligible for large group coverage through the Policyholder. In this instance, the Employer may apply for coverage that complies with the requirements arising out of its status as a small or large employer as defined by applicable state or federal law.

3. The Policyholder intends to establish, sponsor, plan sponsor and endorse an employee benefit plan which will be governed by ERISA. The Policyholder is the ERISA plan administrator. The Policyholder controls health insurance decisions, including the eligibility requirements for coverage and the Policy's renewal date. If the eligibility requirements on this Employer Enrollment Form do not match the eligibility requirements selected by the Policyholder, the eligibility requirements selected by the Policyholder control.

4. Humana is the claims administrator, and as the claims administrator, will in accordance with state and federal law interpret Policy, Group Plan, or Group Contract provisions, make decisions regarding eligibility for coverage and benefits, and resolve factual questions relating to coverage and benefits.

5. The Policy will be treated as a large group health plan, as defined by 42 C.F.R. § 411.101, and accordingly, will pay primary to Medicare for (a) Medicare beneficiaries age 65 or older who are covered under the Policy by virtue of the individual's current employment status with the Employer or the current employment status of a spouse of any age; and (b) Medicare beneficiaries who are under age 65, entitled to Medicare on the basis of disability, and covered under the Policy by virtue of the individual's or a family member's current employment status with the Employer..

6. If the Employer fails to pay premium when due, coverage may be subject to termination as specified under the terms of the Policy. Coverage is continued monthly subject to timely payment of premium. Humana reserves the right to change the premium rates on any premium due date, as permitted by applicable law. Humana will provide advance written notice of any change of premium rates to a representative of the Employer.

7. By electing coverage under the Policy, the Employer will be subject to COBRA and agrees to waive the small employer exemption described under 26 U.S.C. § 4980B(d), if applicable.

8. Upon request, the Employer shall provide information or records that Humana determines are relevant to this Employer Enrollment Form and group coverage for inspection by the Policyholder, Administrator, Humana, or a representative of Humana.

9. Humana reserves the right to recalculate the rates if final enrollment due to demographic changes which are due to age, sex, coverage type, geographic area, that, in the aggregate, would impact premium more than 5%. Humana reserves the right to recalculate the rates based on final enrollment/participation.

10. Humana has the right to use information provided by me to determine whether this Employer Enrollment Form will be accepted or declined and to establish appropriate premiums.

11. I have read this Employer Enrollment Form and the information I have provided is accurate and complete and can be substantiated by the Employer's records.

12. I have received and reviewed the applicable regulatory information and the Humana issued proposal, and I have referred to the proposal to select benefit plan(s) and confirmed my selection from the Humana issued proposal before signing below.

13. By executing this Employer Enrollment Form, I understand and agree to its terms and represent and warrant that the Employer shall comply with the terms of the Policy and all applicable law. The Employer has the right to receive a copy of the Policy from the Policyholder.

14. Coverage is not in effect unless and until the Employer receives written notice from Humana that Humana has issued coverage.

15. This Employer Enrollment Form will form part of any contract or coverage issued.

16. The Agent and I do not have the authority to waive a complete answer to any question, determine coverage or insurability, alter any contract, bind Humana by making any promise or representation, or waive any of Humana's other rights or requirements. No waiver or change will bind Humana unless signed by an authorized officer of Humana.

17. Intentional fraud or intentional misrepresentation of a material fact may void, reduce or increase past premium, or terminate an individual's coverage or group's coverage. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

DO NOT CANCEL ANY CURRENT GROUP COVERAGE UNTIL YOU RECEIVE WRITTEN NOTICE FROM US THAT WE HAVE ISSUED COVERAGE.

Dated on: _____ (month, day, year) at _____ (city and state)

By _____ _____ _____

Group authorized representative (Printed name) (Signature) (Title)

8. AGENT INFORMATION

1. Agency of Record (for commissions and correspondence)	**2. Agent/Agency of Record** (for split commissions)
Name (print or type)	Name (print or type) ABC Benefits Group
Tax ID/Social Security Number/Humana Agent Number	Tax ID/Social Security Number/Humana Agent Number 45-5161021
Commission split ☐ No ☑ Yes If yes, percentage: ___80___ (equals 100%)	Commission split ☐ No ☑ Yes If yes, percentage: ___20___ (equals 100%)
1. Writing Agent/Broker Producer	**2. Agent/Agency of Record**
Name (print or type)	Name (print or type) John E Gaylor
Tax ID/Social Security Number/Humana Agent Number	Tax ID/Social Security Number/Humana Agent Number 1705911
Commission split ☐ No ☑ Yes If yes, percentage: ___80___ (equals 100%)	Commission split ☐ No ☑ Yes If yes, percentage: ___20___ (equals 100%)

General Agency (Complete only if agency involved in sale)

General agency information pertains to: ☐ Agency of Record ☐ Writing Agent	
Name (print or type)	Tax ID/Social Security Number/Humana Agent Number

As the Agent, I acknowledge that I am responsible to meet with the group submitting this Employer Enrollment Form in order to fully and accurately represent the terms and conditions of the plans and services of the offering or insuring entity, or one of its subsidiaries. These provisions are available to me and the group in the Regulatory Pre-enrollment Disclosure Guide or other plan literature.

Writing Agent signature: _____ Date: _____