51+ Employer/Group Application - California

Kanawha Insurance Company

Humana.com

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in the Large Group/Employer Application as "Humana".

Short Term Disability,and Long Term Disability,and Life,and Workplace Voluntary Benefits plans insured or administered by **Kanawha Insurance Company**.

Internal use only	Group number:

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

Full legal business name				Requested effective date __ / __ / ____
Corporate/Situs location street address (P.O. Box not allowed)	City	State	ZIP code	County

Type of business ☐ Corporation ☐ Partnership ☐ Sole Proprietorship ☐ Church or Government entity ☐ Other (explain) ____________	Date company established	Federal Tax ID
Nature of business/SIC code	Business phone number ( )	Business fax number ( )

Do you have more than one location? ☐ No ☐ Yes

Benefit Administrator/Management contact name:

Phone number ( )	Fax number ( )	E-mail

Management contact: Mother's maiden name ____
(this will be used to gain access to the Employer Self-Service Center on www.Humana.com)

Billing contact name:

Billing address (N/A, if same as street address)	City	State	ZIP code

Phone number ( )	Fax number ( )	E-mail

Are separate divisions/classes required for billing or reporting? ☐ No ☐ Yes If yes, please explain. If additional space is needed, please attach an additional page. Each additional page must be signed and dated.

For Workplace Voluntary Benefits: Effective date of policy and due date of first premium will be (month, day, year) __ / __ / ____

Type of Billing: ☐ Self Billed ☐ Listed Billed **Premium mode:** ☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual

2. ELIGIBILITY REQUIREMENTS

Number of employees on payroll ___________. An employee who is eligible to apply for insurance is one who is actively at work on a full-time basis working at least the number of hours per week as indicated in the table below.

	All	**STD**	**LTD**	**Group Critical Illness**	**Workplace Voluntary Benefits**
A. Number of hours worked per week to be eligible (select between 20 and 40 hours)					
B. Number of employees in a probationary waiting period (do not include in the eligible count below in C)					
C. Total number of eligible employees					
Number of employees:					
• waiving with other qualifying coverage					
• waiving without other qualifying coverage					
Number of employees to be enrolled					

2. ELIGIBILITY REQUIREMENTS (continued)

Probationary waiting period for eligible employees ☐ 0 days ☐ 30 days ☐ 60 days ☐ 90 days ☐ Other (specify)_______
If you prefer months, please select "Other" and specify the number of months.

Employee effective provision: (The employee termination date coincides with the effective date provision.)
☐ First of month following probationary waiting period
☐ Immediately following probationary waiting period (required for 90 day probationary waiting period)

STD/LTD only (Employee termination date is last day of employment.)
Waiting period: current employees ☐ Eligible on date of employment ☐ Eligible after active employment for _____ days
Waiting period: rehired/new employees ☐ Eligible on date of employment ☐ Eligible after active employment for _____ days

Do you want to exclude a class of employees? ☐ No ☐ Yes
If yes, check class to exclude: (Options vary by plan. Refer to the Underwriting Requirements for each plan.)
☐ union ☐ non-union ☐ hourly ☐ salary ☐ management ☐ non-management ☐ other:____________________

Employee Eligibility by Class
According to Federal Patient Protection and Affordable Care Act Public Law 111-148, an employer's group health plan cannot discriminate in favor of highly-compensated employees. Doing so may result in a penalty. To avoid penalties, please review any class-based benefits with your legal or financial advisor to ensure your group health plan does not favor highly compensated employees. (Excludes grandfathered health plans).

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

Is this a Collectively Bargained Plan? ☐ No ☐ Yes Name of Plan ____________________
Plan number ____________________(Assigned by Employer for use in filing IRS form 5500)

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

Short Term Disability, Long Term Disability, and Group Critical Illness only

Effective dates for changes in amounts of coverage	Effective first day of month following change	Other
Increases/decreases due to change in class	☐	
Increases/decreases requested by employee	☐	
Increases (with Evidence of Insurability) requested by employee	☐	
Decreases due to age	☐	

Evidence of Insurability required if amount of coverage applied for exceeds amounts below:

	Class 1	Class 2		Class 1	Class 2
Employee STD	$	$	Basic group critical illness	$	$
Employee LTD	$	$	Buy-up group critical illness		

☐ **Special requests:** Check box and attach signed additional sheet or letter, if custom dating, face amounts, etc. are desired.

W-2 Services Option (Please choose one)
☐ Option 1: Withhold state and federal income taxes, and the employee's portion of FICA. Prepare and file W-2 Forms.
☐ Option 2: Withhold federal income taxes, and the employee's portion of FICA. Applicant waives W-2 Forms services.

A detailed description of the W-2 services elected by applicant pursuant to this Application will be sent to the applicant via mail. Such services will be performed in accordance with the above election and established as standard procedures.

3. EMPLOYER CONTRIBUTION(S)

STD and LTD only: Are employer contributions taxed in employee paychecks? ☐ No ☐ Yes

Coverage - Employer's contribution for: (Indicate $ or % amount)	**STD**	**BUY UP STD**	**LTD**	**BUY UP LTD**	**Workplace Voluntary Benefits**
Employee					
Employee/spouse/domestic partner	N/A	N/A	N/A	N/A	
Employee/child	N/A	N/A	N/A	N/A	
Family	N/A	N/A	N/A	N/A	

4. PRIOR/CURRENT CARRIER INFORMATION

	STD	**LTD**
Is this group transferring from another group carrier?	☐ No ☐ Yes	☐ No ☐ Yes
If yes, provide carrier name		
Proposed termination date		

For Workplace Voluntary Benefits - Existing coverage available to employees

Disability income carrier ____________________ ☐ Individual ☐ Group Coverage termination date____________

CI/Cancer carrier ____________________ ☐ Individual ☐ Group Coverage termination date____________

5. PRODUCT SELECTION - To complete this section, please refer to the Underwriting Requirements (reorder CA-52347-KIC). Please refer to your quote for the plan's name. Also review the Regulatory Pre-enrollment Disclosure Guide with your agent, broker, or producer.

a. SHORT TERM DISABILITY (group sizes 10+) Attach additional signed and dated sheets (reorder CA-52336), if necessary.

Name of Class 1	
Funding type	☐ Contributory ☐ Non-contributory ☐ Voluntary
Benefit schedule (select one)	☐ 50% ☐ 60% ☐ 66.67% ☐ Other __________ ☐ Flat amount $ ________ ☐ Incremental amount $________
Weekly benefit minimum	$__________
Weekly benefit maximum	$
Earnings definition	☐ Base salary ☐ Average ________ months bonus ☐ Average ________ months commission ☐ Other__________
Duration weeks	☐ 13 ☐ 26 ☐ 52 ☐ Other _____
Elimination period (accident/sickness)	☐ 1/8 ☐ 8/8 ☐ 15/15 ☐ 30/30 ☐ Other _____
Pre-existing limitation	☐ None ☐ 3/3/12 ☐ Other _____
Rate guarantee	☐ 1 Year ☐ 2 Years ☐ Other _____

Name of Class 2	
Funding type	☐ Contributory ☐ Non-contributory ☐ Voluntary
Benefit schedule (select one)	☐ 50% ☐ 60% ☐ 66.67% ☐ Other __________ ☐ Flat amount $ ________ ☐ Incremental amount $________
Weekly benefit minimum	$__________
Weekly benefit maximum	$
Earnings definition	☐ Base salary ☐ Average ________ months bonus ☐ Average ________ months commission ☐ Other__________
Duration weeks	☐ 13 ☐ 26 ☐ 52 ☐ Other _____
Elimination period (accident/sickness)	☐ 1/8 ☐ 8/8 ☐ 15/15 ☐ 30/30 ☐ Other ______
Pre-existing limitation	☐ None ☐ 3/3/12 ☐ Other _____
Rate guarantee	☐ 1 Year ☐ 2 Years ☐ Other _____

b. LONG TERM DISABILITY (group sizes 10+) Attach additional signed and dated sheets (reorder CA-52336), if necessary.

Name of Class 1	
Funding type	☐ Contributory ☐ Non-contributory ☐ Voluntary
Benefit schedule (select one)	☐ 50% ☐ 60% ☐ 66.67% ☐ Other ________ ☐ Incremental amount $_______
Monthly benefit minimum	☐ $100 or 10% of monthly salary ☐ Other _________
Monthly benefit maximum	$
Earnings definition	☐ Base salary ☐ Average _________ months bonus ☐ Average _________ months commission ☐ Other____________
Duration	☐ 2 Years ☐ 5 Years ☐ SSNRA ☐ Other ______
Elimination period	Days: ☐ 30 ☐ 60 ☐ 90 ☐ 180 ☐ Other ______
Definition of disability	Year own occupation: ☐ 2 ☐ 3 ☐ to age 65 ☐ Other ______
Pre-existing limitation	☐ 3/3/12 ☐ 6/6/12 ☐ 3/12 ☐ 6/12 ☐ Other ______
Mental health and substance abuse limitation	☐ 24-month outpatient ☐ 12-month outpatient ☐ Other ______
Rate guarantee	☐ 1 Year ☐ 2 Years ☐ Other ______

Name of Class 2	
Funding type	☐ Contributory ☐ Non-contributory ☐ Voluntary
Benefit schedule (select one)	☐ 50% ☐ 60% ☐ 66.67% ☐ Other ________ ☐ Incremental amount $_______
Monthly benefit minimum	☐ $100 or 10% of monthly salary ☐ Other _________
Monthly benefit maximum	$
Earnings definition	☐ Base salary ☐ Average _________ months bonus ☐ Average _________ months commission ☐ Other____________
Duration	☐ 2 Years ☐ 5 Years ☐ SSNRA ☐ Other ______
Elimination period	Days: ☐ 30 ☐ 60 ☐ 90 ☐ 180 ☐ Other ______
Definition of disability	Year own occupation: ☐ 2 ☐ 3 ☐ to age 65 ☐ Other ______
Pre-existing limitation	☐ 3/3/12 ☐ 6/6/12 ☐ 3/12 ☐ 6/12 ☐ Other ______
Mental health and substance abuse limitation	☐ 24-month outpatient ☐ 12-month outpatient ☐ Other ______
Rate guarantee	☐ 1 Year ☐ 2 Years ☐ Other ______

Additional benefits: Please refer to your proposal for additional benefits available with plan selected. Attach additional signed and dated sheets (reorder CA-52336), if necessary.

Cost of living adjustment (3%)	☐ No ☐ Yes If Yes, ☐ Lesser of 3% or 1/2 CPI ☐ Lesser of 6% or 1/2 CPI Select number of adjustments ☐ 5 ☐ 10
Business income protection	☐ No ☐ Yes If Yes, ☐ 15% to $2,500 ☐ 25% to $5,000
Special conditions limitation	☐ No ☐ Yes If Yes, ☐ None ☐ 12 months ☐ 24 months
Survivor income benefit	**(2-99)** ☐ 3-month gross lump sum ☐ 6-month gross lump sum **(100+ only)** ☐ No ☐ Yes If yes, ☐ 3-month gross lump sum ☐ 6-month gross lump sum
Infectious & contagious disease	☐ No ☐ Yes If Yes, Waiting period: ☐ 6 months ☐ 12 months Earnings loss: ☐ 20% ☐ 40% Duration of benefits: ☐ 2 Years ☐ 3 Years ☐ 4 Years ☐ Duration of claim Benefits cease if earnings exceed: ☐ 80 % ☐ 60 %
Accidental dismemberment and loss of sight	☐ No ☐ Yes If Yes, Loss occurs within: ☐ 90 Days ☐ 180 Days ☐ 365 Days
Extended earnings	☐ No ☐ Yes If Yes, Qualification for benefit: ☐ Less than 60% of PDE ☐ Less than 80% of PDE ☐ Less than 100% of PDE Benefit end date: ___________________ The lesser of ☐ 12 ☐ 24 ☐ 6 ☐ 3 months or when earnings exceed qualification %
Pension contribution	☐ No ☐ Yes
Medical premium supplemental	☐ No ☐ Yes If Yes, Duration of Benefits: ☐ 2 Years ☐ 3 Years ☐ 4 Years ☐ 5 Years ☐ Duration of claim

c. WORKPLACE VOLUNTARY BENEFITS (all group sizes)

DISABILITY INCOME PLUS ☐ No ☐ Yes **Plan design** ☐ Benefits are provided in conjunction with an HSA plan
☐ Benefits will be offered in conjunction with an IRS-qualified pre-tax plan

Benefit period (select all that apply) ☐ 3 Months ☐ 6 Months ☐ 1 Year ☐ 2 Years ☐ 3 Years
Elimination period (select all that apply) ☐ 0/7 ☐ 7/7 ☐ 0/14 ☐ 14/14 ☐ 30/30 ☐ 60/60 ☐ 90/90 ☐ 180/180 ☐ 365/365

Optional Benefits - Employer Selectable ☐ Loss of work ☐ 24-hour coverage ☐ Takeover
☐ Mental, nervous, alcohol and drug abuse ☐ Portability
☐ Sickness elimination period waiver
(available only if 7- or 14-day elimination period is selected for sickness)

Optional Benefits - Employee Selectable ☐ COBRA benefit ☐ Physical Therapy ☐ ICU/CCU

☐ Disability Income Advantage
Base Benefit period (select all that apply) ☐ 3 Month ☐ 6 Month ☐ 1 Year ☐ 2 Year ☐ 3 Year
Elimination period (select all that apply) ☐ 0/7 ☐ 7/7 ☐ 0/14 ☐ 14/14 ☐ 30/30 ☐ 90/90 ☐ 180/180 ☐ 365/365
Optional Riders ☐ 24-hour coverage ☐ Hospital confinement ☐ Takeover
☐ COBRA ☐ Limited mental health/Emotional disease
(only available with EP 0/14, 14/14, or 30/30)

☐ Income Protector (Non-Occ)
Elimination Period (select all that apply) ☐ 0/7 ☐ 7/7 ☐ 0/14 ☐ 14/14 ☐ 30/30 ☐ 90/90 ☐ 180/180
Benefit Period (select all that apply) ☐ 90 Day ☐ 6 Month ☐ 1 Year ☐ 2 Year
Optional Riders ☐ Emergency Accident ☐ Outpatient Sickness ☐ Hospital Indemnity

ACCIDENT ☐ Group ☐ Trust ☐ Individual **Base Plan** ☐ Level 1 ☐ Level 2 ☐ Level 3 ☐ Level 4
☐ Benefits will be offered in conjunction with an IRS-qualified pre-tax plan

Optional Riders (May not be available with all plans.)
☐ Hospital Intensive Care (per day) ☐ $150 ☐ $300 ☐ $450 ☐ $600 ☐ $900
☐ Fracture and dislocation ☐ $750 ☐ $1,500
☐ Accident total disability (elimination period) ☐ 1 Day ☐ 7 Days ☐ 14 Days ☐ 30 Days
☐ On-the-job coverage ☐ Travel/Lodging ☐ Loss of work

CRITICAL ILLNESS - Persons without comprehensive medical coverage are not eligible for this coverage. ☐ No ☐ Yes

Plan design ☐ Benefits will be offered in conjunction with an IRS-qualified pre-tax plan

Coverage choices ☐ Vascular ☐ Cancer ☐ Other critical illnesses 50 or 100% of face amount

Optional Benefits - Employer Selectable ☐ Benefit recurrence ☐ Loss of work ☐ Takeover

Optional Benefits - Employee Selectable ☐ Health screening benefit $_________ ☐ Automatic benefit increase

CRITICAL ILLNESS (Employer paid) **Plan design** ☐ Benefits offered in conjunction with an IRS-qualified pre-tax plan

Coverage choices ☐ Vascular ☐ Cancer ☐ Other group critical illness 50 or 100% of face amount

Optional Benefits - Employer Selectable ☐ None ☐ Benefit recurrence
☐ Takeover ☐ Health screening: ☐ $50 ☐ $100 ☐ $150 ☐ $500
☐ Loss of work

Face amount (employee/member) ☐ Class I Basic: $______ ☐ Class I Buy-up/Optional: $______
☐ Class II Basic: $______ ☐ Class II Buy-up/Optional: $______

Family options ☐ Spouse/Domestic Partner Basic: $______ or ______% of employee/member amount
☐ Buy-up/Optional: $______ or ______% of employee/member amount
☐ Child(ren) Basic: $______ or ______% of employee/member amount
☐ Buy-up/Optional: $______ or ______% of employee/member amount

Maximum benefit amount ☐ Basic: $_______ ☐ Buy-up/Optional: $______

c. WORKPLACE VOLUNTARY BENEFITS (continued)

CRITICAL LIFE ☐ No ☐ Yes **Plan design** ☐ 10 Year ☐ 20 Year
Optional Benefits - Employer Selectable ☐ Waiver of premium ☐ Loss of work ☐ Takeover
☐ Additional benefit increase ☐ Accelerated living benefit - critical illness _____%
☐ Accidental death and loss of sight dismemberment

CANCER - Persons without comprehensive medical coverage are not eligible for this coverage ☐ Cancer Expense
☐ Group Lump Sum Cancer

☐ Benefits will be offered in conjunction with an IRS-qualified pre-tax plan
Optional Riders - Cancer Expense ☐ Hospital indemnity ☐ Lump sum first diagnosis
Optional Benefits - Group Lump Sum Cancer Employer selectable ☐ Benefit recurrence ☐ Loss of work ☐ Takeover benefit
Optional Benefits - Group Lump Sum Cancer Employee selectable ☐ Health Screening $__________
☐ Automatic benefit increase

WHOLE LIFE ☐ Whole Life 65 ☐ Whole Life 99
Optional Riders ☐ Waiver of premium ☐ AD&D ☐ Loss of work ☐ Automatic benefit increase ☐ Family Term
☐ Employee Term to Age 65

SUPPLEMENTAL HEALTH - Persons without comprehensive medical coverage are not eligible for this coverage ☐ No ☐ Yes
☐ Benefits will be offered in conjunction with an IRS-qualified pre-tax plan

Base plan	☐ Plan A	☐ Plan B	☐ Plan C	☐ Plan D
Hospital Indemnity	$100/day	$200/day	$300/day	$500/day
Hospital First Occurrence	$250/day	$500/day	$500/day (days 1-2) $750/day (days 3-4)	$500/day (days 1-2) $1,000/day (days 3-4)
Optional benefits - Employer selectable				
☐ ICU/CCU/Burn Unit benefit	$100/day	$200/day	$600/day	$1,000/day

If multiple plans are selected and plan availability is limited by class, please list what class of employees are eligible for each plan.

6. THE FOLLOWING APPLIES TO ALL COMPANIES AND PLANS EXCEPT WORKPLACE VOLUNTARY BENEFITS

The companies listed on this Employer Group Application (EGA), severally or collectively as the context may require, are referred to in this EGA as we, us, and our.

In accordance with Section 503 of ERISA, as claims administrator we have authority to make decisions consistent with the terms of the Policy or Certificate regarding (1) eligibility for coverage; (2) paying claims for benefits; (3) interpretation of Policy or Certificate provisions; and (4) resolution of factual questions relating to coverage and benefits.

You, the participating employer, policyholder, contractholder, or Certificate sponsor, intend to establish, sponsor, plan 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.

7. THE FOLLOWING APPLIES TO ALL COMPANIES AND PLANS

You agree to make available your participation and eligibility records, including all records directly related to employees' coverage, which we determine are relevant to this EGA and group coverage for inspection by the Trustee, Administrator, us, or our representative during your normal business hours. You agree to make this information available to us for the term of the Policy. As required by law, we maintain the privacy of personal and health information.

If you fail to pay premium when due, coverage may be subject to termination as specified under the terms of the Policy or Certificate. 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. You will receive advance written notice.

For you to remain eligible for the Policy or Certificate, the eligibility, underwriting, participation, and contribution requirements must be maintained, for each respective coverage.

Failure to maintain the plan eligibility, underwriting, participation and contribution requirements will terminate your coverage under the Policy or Certificate.

We have the right to use information provided by you and any employee, dependent or individual to determine whether this EGA will be accepted or declined and to establish appropriate premiums. We will not use any health-related information to decline coverage to an employee, dependent or individual if this EGA is accepted. We will administer this in a non-discriminatory manner.

8. AGREEMENT AND SIGNATURE - Review your policy/certificate carefully

You the employer, policyholder, contract holder, or Certificate sponsor understand, agree, and represent: You have read this Employer/Group Application (EGA) and the information you provided is accurate and complete to the best of your knowledge and belief and can be substantiated by your business records. You have received and reviewed the quote and the applicable required regulatory information. Neither you nor the agent 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. For action to be taken on this EGA, the first month's estimated premium (which may include a monthly administrative fee) and fully completed enrollment information for all employees and dependents must be submitted with the EGA. Coverage is not in effect unless and until you receive written notification from us. You will provide the documentation requested by us which establishes that all eligibility, underwriting, and participation requirements of the plan are met. An act of fraud or an intentional misrepresentation of a material fact may void or terminate an individual's or group's coverage as specified under the terms of the Policy or Certificate. Providing incomplete, inaccurate, or untimely information may void, reduce, or increase past premium, or terminate an individual's coverage or the group's coverage. This EGA will form part of any contract or coverage issued. If this EGA is declined, we will return the premium deposit submitted with this application. The original version of this Agreement is in the English language. If there are any discrepancies or conflicts between the English and any other version that has been translated into another language, the English version will control.

CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH INSURANCE COMPANIES AS A CONDITION OF OBTAINING HEALTH INSURANCE COVERAGE.

If you provide a false statement with the intent to deceive a material fact or if any false statement you make materially affected either the acceptance of the risk or the hazard assumed by us, we may reduce or void the contract within the contestable period.

If you decide not to sign this EGA, we will decline to enroll you in an insurance product or to give you insurance benefits.

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

Dated on: ______________________ (month, date, year) at ______________________ (city and state)

By: ______________________ ______________________ ______________________
(Employer printed name) (Employer signature) (Title)

For Workplace Voluntary Benefits - only necessary for non-employer groups.

By: ______________________ ______________________ ______________________
(Plan sponsor printed name) (Plan sponsor signature) (Title)

9. AGENT/BROKER/PRODUCER 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)
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%)	Commission split ☐ No ☐ Yes If yes, percentage: (total should equal 100%)
1. Writing Agent/Broker/Producer	**2. Writing Agent/Broker/Producer**
Name (print or type)	Name (print or type)
Social Security Number/Humana Agent Number	Social Security Number/Humana Agent Number
Commission split ☐ No ☐ Yes If yes, percentage: (total should equal 100%)	Commission split ☐ No ☐ Yes If yes, percentage: (total should equal 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/Humana Agent Number		
Rogers Benefit Group			
Address	City	State	ZIP code
11555 Sorrento Valley Road #203	San Diego	CA	92121

In accordance with 10 California Code of Regulations, Section 2274.76, did you help or advise and/or answer questions regarding the application (including electronically), medical health questions or health insurance for any applicant? ☐ No ☐ Yes

If yes, who did you help? ______________________________

As the Writing Agent/Broker/Producer, I acknowledge that I am responsible to meet with the employer submitting this Employer Group Application 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 employer in the other plan literature.

Writing Agent/Broker/Producer's Signature:______________________________ Date:__________________

Application for Group Insurance

WORKPLACE VOLUNTARY BENEFITS

ARIZONA

Humana.com

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in this Application for Group Insurance as "Humana," "We," or "Our."

Workplace Voluntary Benefit plans insured or administered by Kanawha Insurance Company.

For existing group, please provide current Group number:

GROUP INFORMATION: Please type or print clearly

Group name:				Requested effective date of policy __/__/____
Corporate/Situs location street address:	City:	State:	ZIP code:	County:

ELIGIBILITY REQUIREMENTS

Number of eligible employees/members:	Number of hours worked per week to be eligible (selection between 20 and 40 hours):
☐ Benefits are provided in conjunction with a HSA Plan ☐ Benefits are offered in conjunction with an IRS qualified pre-tax plan	Payroll Deduction Frequency ☐ Weekly ☐ Bi-weekly ☐ Semi-monthly ☐ Monthly ☐ Other, please indicate:

PLAN SELECTION – Please review the Regulatory Pre-enrollment Disclosure Guide with your agent, broker or producer.

Sold quote number: ______________________________________

Accident	☐ Electing	**Supplemental Health**	☐ Electing	**Term Life**	☐ Electing
Critical Illness	☐ Electing	**Disability Income**	☐ Electing	**Whole Life**	☐ Electing
Hospital Indemnity	☐ Electing	**Cancer Only Benefits**	☐ Electing		

GROUP AGREEMENT AND SIGNATURE

If We approve this Application for Group Insurance, a policy will be issued. The applicant agrees that acceptance of the policy will be an approval of the policy terms. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

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

By: _____________________________________ _____________________________________ __________________________

Group Authorized Representative (Print name) (Signature) (Title)

AGENT INFORMATION

As the Agent, I acknowledge that I am responsible to meet with the group submitting this Application for Group Insurance 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 1

Name (print or type)	Date
Humana Agent/Tax ID Number	Signature
Agent/Agency of Record (AOR)	Humana Agent/Tax ID Number
Is there a case split? ☐ No ☐ Yes If yes, Agent 1 ______ %	Agent 2 ______ %

Writing Agent 2

Name (print or type)	Date
Humana Agent/Tax ID Number	Signature
Agent/Agency of Record (AOR)	Humana Agent/Tax ID Number