

# Employer Group Application (all group sizes)



## LOUISIANA

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

Medical, Dental and Vision plans provided by Humana Health Benefit Plan of Louisiana, Inc. Life plans insured by Humana Insurance Company.

### 1. GROUP INFORMATION - Please type or print clearly in black ink

Group number: \_\_\_\_\_

Group name:				Requested effective date __/__/__	
Corporate/Situs location street address:		City:	State:	ZIP code:	Parish:
Date company established (MM/DD/YYYY):	Federal Tax ID:	Nature of business/SIC code:		Phone number:	
<b>Benefit Administrator/management contact name:</b>					
Phone number:			Email address:		
<b>Billing contact name:</b>					
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? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please explain. Attach additional signed and dated sheets, if necessary.					

### 2. ELIGIBILITY REQUIREMENTS

<b>Average total number of employees</b>	<input type="text"/>	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.			
<b>Average number of full-time equivalent employees</b>	<input type="text"/>	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: <ul style="list-style-type: none"> <li>number of <b>full-time employees</b> (who worked 30 hours or more per week on average); plus</li> <li>total number of hours worked by <b>part-time employees</b> during the month capped at 120 hours, divided by 120.</li> </ul>			
Eligible employee count (including those employees who waive coverage):	<b>Medical</b>	<b>Dental</b>	<b>Vision</b>	<b>Life</b>	
Are you offering coverage to retirees (Non-Community Rated Medical, Dental and Vision)? <input type="checkbox"/> No <input type="checkbox"/> Yes					
Required age (minimum 50):		Minimum years of service:			
Number of retirees to be covered:	<b>Medical:</b>	<b>Dental:</b>	<b>Vision:</b>		
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? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, enter information below:					
<b>Company name</b>				<b>Total employees</b>	
Probationary waiting period for eligible employees: <input type="checkbox"/> 0 days <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days 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): <input type="checkbox"/> First of the month following probationary waiting period (required for HMO plans requiring referrals) <input type="checkbox"/> 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  
 COBRA is for continuation of coverage for employers with 20 or more employees. State Continuation is for employers with less than 20 employees.

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 LA-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
		<input type="checkbox"/> COBRA <input type="checkbox"/> State Continuation				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/> COBRA <input type="checkbox"/> State Continuation				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/> COBRA <input type="checkbox"/> State Continuation				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/> COBRA <input type="checkbox"/> State Continuation				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**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

Sold quote number: \_\_\_\_\_

Plan 1 name \_\_\_\_\_ / Reference # \_\_\_\_\_

Plan 2 name \_\_\_\_\_ / Reference # \_\_\_\_\_

Plan 3 name \_\_\_\_\_ / Reference # \_\_\_\_\_

Plan 4 name \_\_\_\_\_ / Reference # \_\_\_\_\_

Attach additional signed and dated sheets (reorder LA-52659), if necessary.

Do you offer a supplemental medical plan that partially or completely subsidizes any member cost-sharing including, but not limited to, deductible, coinsurance, or co-pays and/or have purchased or created a funding mechanism which will fund an Employee Spending Account at a level that exceeds 30% of the plan deductible?  No  Yes If yes, indicate amount funded \$ \_\_\_\_\_

**EMPLOYER CONTRIBUTION** (Percentage or dollar amount): Minimum employer contribution toward employee premium is [0]% or \$[0].  
 Employee: \_\_\_\_\_ Employee/Spouse: \_\_\_\_\_ Employee/Child: \_\_\_\_\_ Family: \_\_\_\_\_

<b>Participation</b> – Available to employers with one or more enrolled employees and • Non-contributory - 100 % • Contributory - 25%	Number of employees waiving with other qualifying coverage:	Number of employees waiving without other qualifying coverage:	Number of employees enrolled:

**Additional Product Selection (may not be available for all group sizes):**  
 Health Care Flexible Spending Account (FSA)  Dependent Care Flexible Spending Account (FSD)  Health Savings Account (HSA)  
 Personal Care Account offered with plan specification:

**5. HEALTH QUESTIONNAIRE** (for Non-Community Rated groups):

1. Are there any disabled dependents over the age of 26 to be covered in this group? If yes, please provide on a separate sheet of paper (form# LA-52662): name of employee, dependent name, statement of disability/ diagnosis from attending physician, dependency statement from employee and the name of the current group carrier insuring the dependent.	<input type="checkbox"/> No <input type="checkbox"/> Yes
2. Has any employee been unable to work 10 or more consecutive days in the past 12 months due to an illness or injury?	<input type="checkbox"/> No <input type="checkbox"/> Yes
3. Is any employee presently not performing his or her duties on a full-time basis due to an illness or injury?	<input type="checkbox"/> No <input type="checkbox"/> Yes
4. To the best of your knowledge, is there any employee, individual in a retiree class, dependent (spouse/domestic partner or child), COBRA beneficiary, or individual within their COBRA/State Continuation election period: <ul style="list-style-type: none"> <li>• confined at home, in a hospital or in a treatment facility</li> <li>• who incurred more than \$25,000 of medical expenses in the past 12 months</li> <li>• who has been advised within the last 90 days to have surgery or be hospitalized</li> <li>• who is eligible for and/or covered by Medicare related to a disability or End-Stage Renal Disease</li> </ul>	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes
5. To the best of your knowledge, is there any employee, individual in a retiree class, dependent (spouse/domestic partner or child), COBRA beneficiary, or individual within their COBRA/State Continuation election period 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:	
AIDS or an AIDS-related complex or other immune system disorder	<input type="checkbox"/> No <input type="checkbox"/> Yes
Diabetes or any disease or disorder of the kidneys, liver or lungs	<input type="checkbox"/> No <input type="checkbox"/> Yes
Coronary artery disease, chest pain, heart surgery, or any disease of the arteries, or blood disorders; hemophilia	<input type="checkbox"/> No <input type="checkbox"/> Yes
Systemic disease including, but not limited to Lupus, Multiple Sclerosis or Multiple Dystrophy	<input type="checkbox"/> No <input type="checkbox"/> Yes
Stroke; Transient Ischemic Attack (TIA)	<input type="checkbox"/> No <input type="checkbox"/> Yes
Alcohol or drug abuse or dependence, or psychological disorder	<input type="checkbox"/> No <input type="checkbox"/> Yes
Cancer, and/or cancerous tumor; including skin cancer	<input type="checkbox"/> No <input type="checkbox"/> Yes
Organ transplant (other than corneal)	<input type="checkbox"/> No <input type="checkbox"/> Yes
Stomach, gall bladder, digestive, intestinal, or colon disorders	<input type="checkbox"/> No <input type="checkbox"/> Yes
6. Does your company currently sponsor short or long term disability? If yes, are any employees currently receiving benefits? Please indicate:	<input type="checkbox"/> No <input type="checkbox"/> Yes

If you answered yes to questions 2-5 above, please indicate the question number and explanation. Attach additional signed and dated sheets (LA-52661), if necessary.

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 R=Retiree

**6. DENTAL PLAN SELECTION**    Electing    Not electing

Sold quote number: _____			
Plan 1 name _____	/ Reference # _____		
Plan 2 name _____	/ Reference # _____		
Plan 3 name _____	/ Reference # _____		
Attach additional signed and dated sheets (reorder LA-52659), if necessary.			
<b>EMPLOYER CONTRIBUTION</b> (Percentage or dollar amount): Minimum employer contribution toward employee premium is [0]% or \$[0].			
Employee:	Employee/Spouse:	Employee/Child:	Family:
<b>Participation</b> - Available to employers with one or more enrolled employees and <ul style="list-style-type: none"> <li>• Non-Contributory plan - 100%</li> <li>• Contributory plan - 50%</li> <li>• Voluntary plan - minimum of 2 enrolled</li> </ul>	Number of employees waiving with other qualifying coverage:	Number of employees waiving without other qualifying coverage:	Number of employees enrolled:
<b>CURRENT CARRIER</b>			
Is this group transferring group dental coverage from another group carrier? <input type="checkbox"/> No <input type="checkbox"/> Yes			
Does prior coverage include orthodontia? <input type="checkbox"/> No <input type="checkbox"/> Yes			
If yes, provide carrier name: _____		Proposed termination date: _____	

**7. VISION PLAN SELECTION**  Electing  Not electing

Sold quote number: \_\_\_\_\_

Plan 1 name \_\_\_\_\_ / Reference # \_\_\_\_\_

Plan 2 name \_\_\_\_\_ / Reference # \_\_\_\_\_

Dual choice arrangements are subject to underwriting review.

**EMPLOYER CONTRIBUTION** (Percentage or dollar amount): Minimum employer contribution toward employee premium is [0]% or \$[0].

Employee: \_\_\_\_\_ Employee/Spouse: \_\_\_\_\_ Employee/Child: \_\_\_\_\_ Family: \_\_\_\_\_

<b>Participation</b> - Available to employers with: <ul style="list-style-type: none"> <li>• one or more enrolled employees when sold with medical and/or dental;</li> <li>• five or more enrolled when standalone; and                         <ul style="list-style-type: none"> <li>• Non-Contributory plan - 100%</li> <li>• Contributory plan - 50%</li> <li>• Voluntary plan - minimum of 5 enrolled</li> </ul> </li> </ul>	Number of employees waiving with other qualifying coverage:	Number of employees waiving without other qualifying coverage:	Number of employees enrolled:

**8. LIFE PLAN SELECTION**

Sold quote number: \_\_\_\_\_ Reference # \_\_\_\_\_

**Basic Life and AD&D** -  Electing  Not electing

**Participation Requirement** - Available to employers with two or more enrolled employees.

- Non-contributory plan - 100%
- Contributory plan - 50%

Rate Guarantee:  2 Year  3 Year

Age Reduction Schedule:  Schedule 1  Schedule 2  Schedule 3

Flat amount \$ \_\_\_\_\_

Salary plan - options are 1x to 7x salary (in .5 increments), rounded to the next highest \$1,000

Salary level: \_\_\_\_ x salary Maximum benefit: \$ \_\_\_\_\_

Class schedule - no more than 2.5x between classes and 10x between the lowest and highest class. Complete the table below.

Class	Description	Flat amount or Salary level
1		
2		
3		
4		

**Basic Dependent Life:**  Electing  Not electing

If yes, indicate volume amount  \$20,000/\$5,000  \$10,000/\$2,500  \$5,000/\$1,000

**Voluntary Employee Life:** Available to employers with five or more or 25% of the eligible employees enrolled, whichever is greater.

Electing  Not electing Reference # \_\_\_\_\_

Do you want AD&D? <input type="checkbox"/> No <input type="checkbox"/> Yes Rate Guarantee: <input type="checkbox"/> 2 Year <input type="checkbox"/> 3 Year Age Reduction Schedule: <input type="checkbox"/> Schedule 1 <input type="checkbox"/> Schedule 2 <input type="checkbox"/> Schedule 3 (Basic and Voluntary Age Reduction Schedules must match) <input type="checkbox"/> Minimum amount \$ _____ <input type="checkbox"/> Maximum benefit \$ _____	<b>Voluntary Dependent Life</b> (only available if Employee Voluntary Life is elected) <input type="checkbox"/> No <input type="checkbox"/> Yes	<b>Dependent Child Voluntary Amount</b> <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000
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**EMPLOYER CONTRIBUTION** (Percentage or dollar amount) for **BASIC** Employee and Dependent Life **ONLY**: Minimum employer contribution toward employee premium is 100%.

Employee: \_\_\_\_\_ Employee/Spouse: \_\_\_\_\_ Employee/Child: \_\_\_\_\_ Family: \_\_\_\_\_

Number of hours worked per week to be eligible (select between 20 and 40 hours): \_\_\_\_\_

**CURRENT CARRIER**

Is this group transferring group life coverage from another group carrier?:  No  Yes

If yes, provide carrier name: \_\_\_\_\_ Proposed termination date: \_\_\_\_\_

As of the date of this application, list any employees currently disabled and not actively at work (attach additional signed and dated pages, if necessary): \_\_\_\_\_

**Accelerated benefits within the policy may be taxable. You should consult your personal tax advisor to assess the impact of the benefit.**

If electing Short Term Disability or Long Term Disability, please complete form # LA-52659. If electing Workplace Voluntary Benefits, please complete form # LA-52658.

## 9. THE FOLLOWING APPLIES TO ALL GROUPS SUBJECT TO ERISA

As claims administrator with authority to make claim determinations as described in Section 503 of the Employee Retirement Income Security Act (ERISA), we make final decisions under the Policy or Group Plan with respect to determining eligibility for coverage and paying claims for benefits, including deciding appeals of denied claims. As claims administrator, we 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, the participating employer, policyholder, contract holder, or Certificate sponsor, intend to establish, sponsor, plan sponsor and endorse an employee benefit plan which will be governed by ERISA. You are the ERISA plan administrator.

## 10. THE FOLLOWING APPLIES TO ALL GROUPS

The group is only eligible if a bona fide business entity exists.

If you fail to pay premium when due, coverage may be subject to termination as specified under the terms of the Policy. You understand and agree that your coverage is continued monthly 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.

You will provide information or records upon request that we determine are relevant to this Employer Group Application and group coverage for inspection by the Trustee, Administrator, us, or our representative. For you to remain eligible you must meet the eligibility, participation and contribution requirements for each respective coverage at all times.

We have the right to use information provided by you to determine whether this Employer Group Application will be accepted or declined and to establish appropriate premiums.

For Non-Community Rated medical groups, 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.

## 11. AGREEMENT AND SIGNATURE – Review your policy/certificate carefully

You, the authorized representative of the group named herein, understand, agree and represent: You have read this Employer Group Application and the information you provided is accurate and complete and can be substantiated by your records. You have received and reviewed the applicable regulatory information and the Humana issued proposal, and you referred to the proposal to select the benefit plan(s) applied for in this Employer Group Application and confirmed your selection from the Humana issued proposal before signing below. By executing this Employer Group Application, you agree to its terms and represent and warrant that you shall comply with the terms of the policy and all applicable law. 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. We shall rely on your representations and any information submitted by you or on your behalf. Providing incomplete, inaccurate or untimely information may reduce an individual's or group's coverage or may increase past premium. Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information or misstatements in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Coverage is not in effect unless and until you receive written notification from us. The Employer Group Application will form part of any contract or coverage issued. 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. 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.

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

Certificate(s) of Insurance/Evidence(s) of Coverage are available to you and your employees on our Web site, [www.humana.com](http://www.humana.com). Your signature on this Employer Group Application represents your agreement to receive electronic delivery of Certificate(s) of Insurance/Evidence(s) of Coverage.

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

By \_\_\_\_\_  
Group authorized representative (Printed name) (Signature) (Title)

## 12. AGENT INFORMATION

<b>1. Agency of Record</b> (for commissions and correspondence)	<b>2. Agent/Agency of Record</b> (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 <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, percentage: _____ (equals 100%)	Commission split <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, percentage: _____ (equals 100%)
<b>1. Writing Agent/Broker Producer</b>	<b>2. Agent/Agency of Record</b>
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 <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, percentage: _____ (equals 100%)	Commission split <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, percentage: _____ (equals 100%)

**General Agency** (Complete only if agency involved in sale)

General agency information pertains to: <input type="checkbox"/> Agency of Record <input type="checkbox"/> 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 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 group in the Regulatory Pre-enrollment Disclosure Guide or other plan literature.

Writing Agent signature: \_\_\_\_\_

Date: \_\_\_\_\_

# Employer Application

## UNDERWRITING REQUIREMENTS

### Medical groups less than 100 employees

You, the participating employer, policyholder, contractholder, or group plan sponsor, may not establish, sponsor, and endorse 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. If less than 10 employees are enrolled, you must submit evidence of health status for all employees and dependents. Humana will not use the evidence of health status to decline medical coverage. Minimum employer contribution toward employee premium is 50%. Retiree coverage is available to employers with 26 or more enrolled employees. Minimum age for retiree coverage is 65 for employers with 26 to 50 enrolled employees.

There are no excluded class options for small group medical coverage. If you do not maintain eligibility, underwriting, and participation requirements, Humana will terminate your coverage.

#### Participation

Non-contributory plans	75%
Contributory plans	75%

For groups of 2-4 eligible employees, Humana requires 75% participation with a minimum enrollment of two. For groups of 5+ eligible employees, Humana requires 75% participation, but will allow 75% participation if the difference is due to valid waivers.

### Medical groups more than 100 employees

Refer to your proposal for complete underwriting requirements. Underwriting approval is required to offer more than one medical carrier to your employees. If you do not maintain eligibility,

underwriting, and participation requirements, Humana will terminate your coverage.

### Dental

Underwriting approval is required to offer more than one dental carrier to your employees. Dental 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 25%. This minimum does not apply to Voluntary coverage. Retiree coverage is available to employers with 26 or more enrolled employees. Minimum age for retiree coverage is 65 for employers with 26 to 50 enrolled employees and must be at least 50 for 51+ enrolled employees. Excluded class options: hourly, salary, union, non-union, management, non-management. If you do not maintain eligibility, underwriting, and participation requirements, Humana will terminate your coverage.

#### Participation requirements

##### Eligible employees

2+ (Employer Pays 100% of Premium)	100%
2+ (Employees Contribute to Premium)	75%
2+ Eligible Employees with Spousal Waiver	50%

##### Participation

#### Voluntary participation requirements:

##### Eligible employees

2+ employees

##### Participation

Two enrolled employees or 25%, whichever is greater.

### Life

Basic Life coverage is available to employers with two or more enrolled employees. Voluntary life coverage is available to employers with five 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%. This minimum does not apply to voluntary coverage. Retirees are not eligible for life coverage. Excluded class options: hourly, salary, union, non-union, management, non-management. If you do not maintain eligibility, underwriting, and participation requirements, Humana will terminate your coverage. 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%. Multiple medical carrier: If you offer more than one medical carrier, you must enroll 100% of those employees who take our coverage regardless of the percentage of contribution paid by you. Five employees or 25%, whichever is greater.

#### Participation requirements

Non-contributory plans	100%
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**Vision**

Underwriting approval is required to offer more than one vision carrier to your employees. Vision 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 75%. Less than 75% requires the selection of a Voluntary Vision product. Retiree coverage is available to employers with 26 or more enrolled employees. Minimum age for retiree coverage is age 65 for employers with 26 to 50 enrolled employees and must be at least age 50 for 51+ enrolled employees. Excluded class options: hourly, salary, union, non-union, management, non-management. If you do not maintain eligibility, underwriting and

participation requirements, Humana will terminate your coverage. Dual choosing Vision products is prohibited.

**Participation requirements:**

10 or more enrolled employees

Group sizes of 2-9 considered if sold with a medical or dental plan with a minimum of 25% participation and no fewer than two enrolled employees.

**Vision Multiple Choice options**

Multiple choice arrangements are not offered for groups with 2-99 lives. For 100+ groups dual-choice arrangements are subject to underwriting review and prior approval.

Medical plans provided by Humana Health Benefit Plan of Louisiana, Inc. Life plans insured or administered by Humana Insurance Company or Kanawha Insurance Company. Dental plans insured or administered by HumanaDental Insurance Company or CompBenefits Insurance Company. Vision plans insured or administered by Humana Health Benefit Plan of Louisiana, Inc., HumanaDental Insurance Company or CompBenefits Insurance Company.