

Notice of Privacy Practices

(privacy practices regarding your personal, health and financial information)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please review it carefully. The privacy of your personal and health information is important. This requires no action on your part unless you have a request or complaint.



Relationships are built on trust. One of the most important elements of trust is respect for an individual's privacy. We at Humana value our relationship with you, and we take your personal privacy seriously.

This notice, effective April 1, 2003, explains Humana's privacy practices, our legal responsibilities, and your rights concerning your personal and health information.

We reserve the right to change our privacy practices and the terms of this notice at any time, as allowed by law. This includes the right to make changes in our privacy practices and the revised terms of our notice effective for all personal and health information that we maintain. This includes information we created or received before we made the changes. When we make a significant change in our privacy practices, we will change this notice and send the notice to our health plan subscribers.

What is personal and health information?

Personal and health information (hereafter referred to as "information") includes both medical information and individually identifiable information, such as your name, address, telephone number or social security number. The term "information" in this notice includes any personal and health information that is created or received by a health care provider or health plan that relates to your physical or mental health or condition, the provision of health care to you, or the payment for such health care.

How does Humana protect my information?

In accordance with federal and state laws and our own policy, Humana has a responsibility to protect the privacy of your information. We have safeguards in place to protect your information in various ways that include:

- Limiting the access to who may see your information
- Limiting how we use or disclose your information
- Informing you of our legal duties regarding your information
- Following our policies
- Training of our associates
- Requesting approval from you for any potential situations where your information would be used for reasons other than payment and health plan operations

How does Humana use and disclose my information?

We must use and disclose your information:

- To you or someone who has the legal right to act on your behalf;
- To the Secretary of the Department of Health and Human Services; and
- Where required by law.

We have the right to use and disclose your information:

- To a doctor, a hospital or other health care provider which asks for it in order for you to receive medical care;
- To pay claims for covered services provided to you by doctors, hospitals or other health care provider;
- For health care operation activities including processing your enrollment, responding to your inquiries and requests for services, coordinating your care, resolving disputes, conducting medical management, improving quality, reviewing the competence of health care professionals, and determining premiums;
- For performing underwriting activities;
- To your plan sponsor to permit them to perform plan administration functions;
- To contact you with information about health-related benefits and services, appointment reminders, or about treatment alternatives that may be of interest to you;

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We may use or disclose your information:

- To your family and friends if you are unavailable to communicate, such as in a medical or other emergency;
- **To provide payment information to the subscriber for Internal Revenue Service substantiation.**
- To public health agencies if we believe there is a serious health or safety threat;
- To appropriate authorities regarding abuse, neglect, or domestic violence;
- In response to a court or administrative order, subpoena, discovery request, or other lawful process;
- For law enforcement purposes;
- To military authorities;
- For research purposes in limited circumstances;
- For procurement, banking or transplantation of organs, eyes, or tissue; and
- To a coroner, medical examiner or funeral director.

Will Humana use my information for purposes not described in this notice?

In all situations other than described in this notice, Humana will request your written permission before using or disclosing your information. You may revoke your permission at any time by notifying us in writing. We will not use or disclose your information for any reason not described in this notice without your permission.

What does Humana do with my information when I am no longer a Humana member?

Your information may continue to be used for purposes described in this notice when your membership is terminated. After the required legal retention period, information is destroyed following strict procedures to maintain the confidentiality of the information.

What are my rights concerning my information?

The following are your rights with respect to your information:

- **Access** – You have the right to review and obtain a copy of your information that may be used to make decisions about you such as claims and case or medical management records. You also may receive a summary of this health information. If you request copies, we may charge you a fee for each page, and per hour for staff time to locate and copy your information, and postage.
- **Alternate Communications** – You have the right to receive confidential communications of

information in a different manner or at a different place to avoid a lifethreatening situation. We will accommodate your request if it is reasonable.

- **Amendment** – You have the right to request an amendment of information we maintain about you if you believe that it is wrong or incomplete. We may deny your request if we did not create the information, we do not maintain the information, or the information is correct and complete. If we deny your request, we will provide you a written explanation of the denial.
- **Disclosure** – You have the right to receive a listing of instances in which we or our business associates have disclosed your information for purposes other than treatment, payment, health plan operations, and certain other activities. Effective April 1, 2003, Humana began maintaining these types of disclosures and will maintain this information for a period of six (6) years. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.
- **Notice** – All Humana members and prospective members have the right to receive a written copy of this notice upon request at any time.
- **Restriction** – You have the right to ask to restrict uses or disclosures of your information. We are not required to agree to these restrictions, but if we do, we will abide by our agreement. You also have the right to agree to or terminate a previously submitted restriction.

How do I exercise my rights or obtain a copy of this notice?

All of your privacy rights can be exercised by obtaining the applicable privacy rights request forms. You may obtain any of the forms by:

- Contacting us at 1-866-861-2762 at any time;
- Accessing our web site at **www.humana.com** and going to the Privacy link, or
- E-mailing us at privacyoffice@humana.com.

The completed request form should be sent to Humana's Privacy Office at:

Humana Inc
Privacy Office
P.O. Box 1438
Louisville, KY 40202

What should I do if I believe my privacy has been violated?

If you believe your privacy has been violated in any way, you may file a complaint with Humana by calling us at 1-866-861-2762 at any time.

You may also submit a written complaint to the U.S. Department of Health and Human Services, Office

of Civil Rights (OCR). We will provide you with the appropriate OCR regional address upon request. You also have the option to email your complaint to OCRComplaint@hhs.gov. We support your right to protect the privacy of your personal and health information. We will not retaliate in any way if you elect to file a complaint with us or with the US Department of Health and Human Services.

Humana follows all federal and state laws, rules, and regulations addressing the protection of personal and health information. In situations when federal and state laws, rules, and regulations conflict, Humana follows the law, rule, or regulation which provides greater member protection.

The following affiliates and subsidiaries also adhere to Humana's privacy policies and procedures:

Humana Employers Health Plan of Georgia, Inc.
Humana Health Insurance Company of Florida, Inc.
Humana Health Plan of Ohio, Inc.
Humana Health Plan of Texas, Inc.
Humana Health Plan, Inc.
Humana Health Plans of Puerto Rico, Inc.
Humana Insurance Company
Humana Insurance Company of Kentucky
Empheys Insurance Company
Humana Insurance of Puerto Rico, Inc.
Humana Medical Plan, Inc.
Humana Wisconsin Health Organization
Insurance Corporation
HumanaDental Insurance Company
The Dental Concern, Inc.
The Dental Concern, Ltd.
Humana Health Plan Interests, Inc.
Humana Health Benefit Plan of Louisiana, Inc.
Health One, Inc.

PRIVACY NOTICE CONCERNING FINANCIAL INFORMATION

Humana and our affiliates understand that the privacy of your personal information is important to you. We take your privacy seriously and your trust in our ability to protect your private information is very important to us. This notice describes our policy regarding the confidentiality and disclosure of personal financial information.

How Does Humana Collect Information About You?

We collect information about you and your family when you complete applications and forms. We also collect information from your dealings with us, our affiliates, or others. For example, we may receive information about you from participants in the health

care system, such as your doctor or hospital, as well as from employers or plan administrators, credit bureaus, and the Medical Information Bureau.

What Information Does Humana Receive About You?

The information we receive may include such items as your name, address, telephone number, date of birth, Social Security number, premium payment history and your activity on our Web site. This also includes information regarding your medical benefit plan, your health care benefits, and health risk assessments.

Where Will Humana Disclose My Information?

We may share your information with affiliated companies and non-affiliated third parties, as permitted by law. We may also provide your information to other financial institutions with which we have joint marketing agreements in order to provide you with offers for products and services you may find of value or which are health-related.

What Can I Prevent With An Opt-Out Disclosure?

You can prevent the disclosures to non-affiliated third parties that provide products and services not offered by Humana or where the non-affiliated company provides services related to your plan by requesting to opt-out of such disclosures. Your opt-out request will apply to all members or individuals covered under your identification number or member account. Your opt-out request will continue to apply until you revoke your request or terminate your membership.

How Do I Request An Opt-Out?

At any time you may instruct Humana not to share any of your personal information with affiliated companies that provide offers of non-Humana products or services. If you wish to exercise your opt-out option, or to revoke a previous opt out request, you need to provide the following information to process your request: your name, date of birth and your member identification number. Any of the methods below can be used to request or revoke your opt-out:

- Telephone us at 1-866-861-2762,
- E-mail your opt-out request to us at privacyoffice@humana.com,
- Send your opt-out request to us in writing:
Humana Privacy Office
P. O. Box 1483
Louisville, KY 40202

Humana follows all federal and state laws, rules, and regulations addressing the protection of personal and health information. In situations when federal and state laws, rules, and regulations conflict, Humana follows the law, rule, or regulation which provides greater member protection.

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Humana Health Plan of Ohio, Inc.
Humana Health Plan of Texas, Inc.
Humana Health Plan, Inc.
Humana Health Plans of Puerto Rico, Inc.
Humana Insurance Company
Humana Insurance Company of Kentucky
Emphesys Insurance Company
Humana Insurance of Puerto Rico, Inc.
Humana Medical Plan, Inc.
Humana Wisconsin Health Organization
Insurance Corporation
HumanaDental Insurance Company
The Dental Concern, Inc.
The Dental Concern, Ltd.
Humana Health Plan Interests, Inc.
Humana HealthBenefit Plan of Louisiana, Inc.
Health One, Inc.
Humana MarketPOINT, Inc.

HUMANA[®]
Guidance when you need it most

Internal use only
Group number:

Employer Group Application

**COLORADO
HUMANA / HUMANADENTAL**

Please refer to your proposal to complete this application.
Print clearly in black ink, and answer all questions or indicate "not applicable."

Your Business Profile

Business name _____ Federal tax ID number _____

Location address (not a P.O. Box) _____

City _____ State _____ Zip code _____ County _____

Do you have more than one location? No Yes

Billing address (if different) _____

City _____ State _____ Zip code _____ County _____

Nature of business or SIC number _____ Date company established _____

Business status: Corporation Partnership Sole Proprietorship Other: (explain) _____

Business phone number _____ Fax number _____

Management contact _____ Administrative contact _____

Management contact e-mail address _____

General Eligibility

Requested effective date _____ How many employees are on your payroll? _____

How many hours per week must your employees work to be eligible?
For large employer groups (51 or more employees), select between 20 and 40 hours.
For small employer groups (2-50 employees) and business groups of one, select between 24 and 40 hours.

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

How long must employees wait after hire date to become eligible? 0 days 30 days 60 days 90 days
 Other, specify: _____

How many employees are eligible for coverage? _____

New employee effective date provision: First of month following waiting period (required for HMO plans)
 Immediately following waiting period
On all plans, the employee termination date coincides with the effective date provision.

Is this employer required to comply with COBRA regulation? No Yes

Is this employer required to comply with state continuation regulation? No Yes

Are any present or former employees/dependents currently on or eligible to elect COBRA/State Continuation? No Yes
If yes, enter information below. Attach a separate sheet if necessary.

Name of applicant	Qualifying event (e.g., termination of employment, divorce, etc.)	Date of qualifying event	Date COBRA or State Continuation coverage terminates

Employer Agreement

You the employer, understand, agree and represent:

- You have read this document and the information you provided is accurate and complete to the best of your knowledge and can be substantiated by your business records.
- You have received and reviewed a proposal and the applicable regulatory information required by your state.
- Neither you nor the agent/broker/producer 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.
- 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 this application. Unless we are informed differently, we will perform a one-time electronic check conversion of the first month's premium payment from the account and for the amount designated on the binder check.
- You will collect any employee contribution toward premium. Our acceptance of premium does not guarantee coverage.
- You will provide the documentation requested by us which establishes that all eligibility, underwriting, and participation requirements of the plan are met.
- Only individuals who meet the eligibility requirements of the plan are eligible to maintain coverage.
- Providing incomplete, inaccurate, or untimely information may void, reduce, or increase past premium, or terminate an individual's coverage or the group's coverage.
- If choosing the HDHP Indexing plan, deductible and out of pocket amounts are established by IRS guidelines. Adjustments to these amounts by the IRS will be made to the policy, without notice, upon renewal of the group.
- If you purchase a three year No Worry package and fail to renew your health insurance plan during the full three year plan period and purchase health insurance with another carrier, you will be subject to an early termination fee of up to \$25,000. Your payment obligation must be satisfied no more than ninety (90) days from the termination date of the three year No Worry plan. If you discontinue offering group health insurance or go out of business, no early termination fee will be assessed.
- Premium can be paid by direct bill or by automated bank withdrawal. To sign up, contact a Humana Billing Representative or register on the employer portal of Humana.com. Electronic payment can be set up for one time payments or for reoccurring monthly withdrawals.
- It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

This document will form part of any contract issued. Coverage is not in effect unless and until you receive written notification from us.

If this application is declined, we will return the premium deposit submitted with this application.

Do not cancel any current group coverage until you receive written notice from us that we have issued coverage.

Dated on: _____ By: _____
 (month, date, year) (employer signature)

Dated at: _____ By: _____
 (city and state) (title)

Agent/Producer Information

<p>1. Agent/Agency of Record (for commissions and correspondence):</p> <p>Name (print) _____</p> <p>Tax ID/Social Security Number _____</p> <p>Commission split: <input type="radio"/> No <input type="radio"/> Yes If yes, percentage: (total should equal 100%) _____</p> <p>1. Writing Agent/Producer:</p> <p>Name (print) _____</p> <p>Social Security Number _____</p> <p>Commission split: <input type="radio"/> No <input type="radio"/> Yes If yes, percentage: (total should equal 100%) _____</p>	<p>2. Agent/Agency of Record (for split-commissions):</p> <p>Name (print) _____</p> <p>Tax ID/Social Security Number _____</p> <p>Percentage of sales: <input type="radio"/> No <input type="radio"/> Yes If yes, percentage: (total should equal 100%) _____</p> <p>2. Writing Agent/Producer:</p> <p>Name (print) _____</p> <p>Social Security Number _____</p> <p>Percentage of sales: <input type="radio"/> No <input type="radio"/> Yes If yes, percentage: (total should equal 100%) _____</p>
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General Agency

General agency information pertains to Agent/Agency of Record #1 Agent/Agency of Record #2

Name (print) _____ Tax ID Number _____

Address _____ City _____ State _____ Zip code _____

As the Writing Agent/Producer, 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 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 Regulatory Pre-enrollment Disclosure or other plan literature.

Writing Agent's Signature: _____ Date: _____

The following applies to all companies and products

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

You, the participating employer or policyholder intend to establish, 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.

Small employer means a person, firm, corporation, partnership or association actively engaged in business, which employed an average of at least two but not more than 50 employees on business days during the preceding calendar year and who employs at least two 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. Effective January 1, 1996, "Small employer" includes a business group of one as defined under Colorado statute.

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.

As claims administrator with authority to make claim determinations as described in Section 503 of 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 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 a 30 day advance written notice, unless a greater period is expressly specified in 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.

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, after your insurance has been in effect under the Policy for six consecutive months. You will receive advance written notice.

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

HUMANA[®]
Guidance when you need it most

Medical plans and Life and Short Term Income Protection plans insured or administered by Humana Insurance Company. HMO plans offered by Humana Health Plan, Inc.

HUMANA
DENTAL

Dental plans insured or administered by HumanaDental Insurance Company or Humana Insurance Company

Humana Small Group Medical

Plan Selection (To complete this information, refer to your proposal.)

	Plan 1	Plan 2	Plan 3
Plan name (as shown on your proposal)			
Office visit copayment (if applicable)	\$	\$	\$
Deductible (if applicable)	Participating: \$ Non-participating: \$	Participating: \$ Non-participating: \$	Participating: \$ Non-participating: \$
Out-of-pocket limit (if applicable)	Participating: \$ Non-participating: \$	Participating: \$ Non-participating: \$	Participating: \$ Non-participating: \$
Network name (if applicable)			

Plan Riders (Please refer to your proposal for rider availability with plan selected.)

	Plan 1	Plan 2	Plan 3
Deductible Carryover Credit	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
Supplemental Accident	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
Vision	Rider no.	Rider no.	Rider no.
Prescription Drug/Retail Card (Level 1 / 2 / 3 / 4)	\$____ / \$____ / \$____ / ____%	\$____ / \$____ / \$____ / ____%	\$____ / \$____ / \$____ / ____%
Prescription Drug/Retail Card (Group A / B / C / D)	\$____ a / \$____ a / \$____ a / \$____ a	\$____ a / \$____ a / \$____ a / \$____ a	\$____ a / \$____ a / \$____ a / \$____ a
Other:	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes

State Plans for groups of 2-50 lives and a business group of one

<p>Colorado Basic Limited Mandate Health Benefit Plan</p> <ul style="list-style-type: none"> • indemnity • preferred provider organization (PPO) <p>Colorado Standard Health Benefit Plan</p> <ul style="list-style-type: none"> • indemnity • preferred provider organization (PPO) • Special state options <ul style="list-style-type: none"> • Colorado Alcoholism • Colorado mental disorder mandated benefit 	<p>Colorado law allows small employers with 2-50 employees and business groups of one, who, since July 1, 1989, have either not provided group health insurance to their employees or have provided coverage from a licensed health insurance company that did not include mental health coverage may waive the Colorado mandated psychological/mental disorders benefits of this plan.</p> <p><input type="radio"/> I meet the above criteria and wish to waive the Colorado mandated mental disorders benefits of this plan. Please provide your current/prior health insurance company's address, phone number, and plan number below.</p>
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Current/Prior Health Insurance Company: _____

Address: _____

Phone number: _____ Plan number: _____

Underwriting Requirements

- You may not sponsor a medical plan from a carrier other than Humana.
- Medical coverage is available to business groups of one and 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.
- For employers with 2-50 employees and business groups of one, you must submit evidence of health status for all employees and dependents. We 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. Retiree coverage is not available when selecting state plans.
- 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 meet and maintain eligibility, contribution, underwriting, and participation requirements, we will terminate your coverage.

Participation

- All plans - 75% of employees eligible for medical benefits who have not waived coverage due to other creditable group coverage.

Colorado State Notices

COLORADO INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY HEALTH BENEFIT PLAN IT MARKETS IN COLORADO TO SMALL EMPLOYERS OF 2-50 EMPLOYEES, INCLUDING A BASIC OR STANDARD HEALTH BENEFIT PLAN, UPON THE REQUEST OF A SMALL EMPLOYER TO THE ENTIRE SMALL GROUP REGARDLESS OF THE HEALTH STATUS OF ANY INDIVIDUALS IN THE GROUP. BUSINESS GROUPS OF ONE CANNOT BE REJECTED UNDER A BASIC OR STANDARD HEALTH BENEFIT PLAN DURING OPEN ENROLLMENT PERIODS AS SPECIFIED BY LAW.

Colorado law 4-6-7 requires Humana Insurance Company to notify small employers with 10 more eligible employees that they are entitled to a choice of composite rates or age banded rates and have the right to see what the premium would be if quoted either way. The total premium quoted will be the same when choosing age or composite rates. However, composite rates show average rates by coverage type and age rates show actual rate for each individual on the census.

Group Information

How much will you contribute to premium? Employee _____% Dependent _____%

Do you wish to have 24-hour coverage for employees not covered by Workers' Compensation? No Yes
If yes, name(s): _____

Are there any other entities associated with this company that are eligible to file a combined tax return? No Yes
If yes, enter information below.

Company Name	Total Employees

Will your employees have access to another carrier's medical coverage by virtue of their employment with you? No Yes
If yes, name of carrier: _____

Did you have prior group medical coverage? No Yes If yes, submit most recent carrier billing with effective and termination dates.

How many medical carriers have you had in the past five years? _____

Is the agent/broker/producer representing you for this application your current agent/broker/producer of record? No Yes

Provide the current and renewal medical insurance premium rates below and attach a copy of your most recent premium bill.
Date of renewal: _____

<p>Current Plan 1 Current carrier rates: Employee: \$ _____ Spouse: \$ _____ Child(ren): \$ _____ Family: \$ _____</p> <p>Plan design: _____</p> <p>Office visit copay: _____</p> <p>Per confinement copay: _____</p> <p>Deductible: • Participating _____ • Non-participating _____</p> <p>Out-of-pocket: • Participating _____ • Non-participating _____</p> <p>Coinsurance stoploss: • Participating _____ • Non-participating _____</p> <p>Emergency room copay: _____</p> <p>Prescription drug benefit: _____</p> <p>Renewal rates: In the parentheses, please indicate the number of employees enrolled in each tier, if available. Employee (): \$ _____ Spouse (): \$ _____ Child(ren) (): \$ _____ Family (): \$ _____</p>	<p>Current Plan 2 Current carrier rates: Employee: \$ _____ Spouse: \$ _____ Child(ren): \$ _____ Family: \$ _____</p> <p>Plan design: _____</p> <p>Office visit copay: _____</p> <p>Per confinement copay: _____</p> <p>Deductible: • Participating _____ • Non-participating _____</p> <p>Out-of-pocket: • Participating _____ • Non-participating _____</p> <p>Coinsurance stoploss: • Participating _____ • Non-participating _____</p> <p>Emergency room copay: _____</p> <p>Prescription drug benefit: _____</p> <p>Renewal rates: In the parentheses, please indicate the number of employees enrolled in each tier, if available. Employee (): \$ _____ Spouse (): \$ _____ Child(ren) (): \$ _____ Family (): \$ _____</p>
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Group Information (continued)

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

If you answered yes to questions 1-3 above, please indicate the question number and explanation.

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/State Continuation R=Retiree Class

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, please explain:

Have any medical benefits now, or within the past 24 months, been funded by you in any manner other than health insurance premium payment? No Yes If yes, please provide details and attach medical claims experience for the applicable time period up to 24 months.

Retiree Information

Are you offering coverage to retirees? (not available when selecting state plans) No Yes If yes, required age:
 Minimum years of service: