Humana.

Internal Use Only
Group Number:

Group Sponsored Medicare Advantage Agreement

Please refer to your proposal to complete this document.
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 _____ County _____

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

Billing address (if different) _____

City _____ State _____ Zip _____ County _____

Nature of business or SIC number _____ Date company established _____

Business Status: Corporation _____ Partnership _____ Sole Proprietorship _____ Other _____

Business Phone Number _____ Fax Number _____

Management Contact _____ Administrative Contact _____

Management Contact e-mail address _____
Administrative Contact e-mail address _____

Effective Date

Requested Effective Date _____

Plan Selection

Plan:	Passive 079	Option:	Custom	Rx Option:	Custom $12/$25/$35/$75
Plan:	Passive Waiver	Option:	Custom	Rx Option:	Custom $12/$25/$35/$75

Group Information

Are any affiliations or subsidiaries to be covered? No _____ Yes _____

If yes: Affiliation _____ Subsidiary _____
Affiliation/subsidiary information: Name _____
Address _____

Eligibility

Total number of Medicare eligible retirees _____ Number of Medicare eligible spouses _____

Number of Medicare retirees to be covered _____ Number of Medicare eligible spouses to be covered _____

How much will the plan sponsor contribute to premium?
Retiree (% or $) _____ Spouse of Retiree (% or $) _____

For the plan to remain in effect, the eligibility, underwriting, and participation requirements must be maintained. Failure to maintain the plan eligibility, underwriting, and participation requirements will terminate the group coverage.

Plan Sponsor Agreement

You, the Plan Sponsor, understand, acknowledge, and agree that:

- You have read this document and the information you provided is accurate and complete to the best of your knowledge and belief.
- You have received and reviewed a proposal and the applicable regulatory information.
- 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.
- 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 premium, or terminate an individual's coverage or the plan coverage.
- The Plan Sponsor can subsidize different premium amounts for different classes of enrollees in a plan provided such classes are reasonable and based on objective business criteria, such as years of service, date of retirement, business location, job category, and nature of compensation (e.g., salaried vs. hourly). Different classes cannot be based on eligibility for the Part D Low-Income Subsidy (LIS). The premium cannot vary for individuals within a given class of enrollees.
- With regard to the Part D premium, the Plan Sponsor cannot charge an enrollee for prescription drug coverage provided under the MA plan more than the sum of his or her monthly beneficiary premium attributable to basic prescription drug coverage and 100% of the monthly beneficiary premium attributable to his or her non-Medicare Part D benefits (if any).
- Also with regard to the Part D premium, the Plan Sponsor must pass through any direct subsidy payments received from CMS to reduce the amount that the beneficiary pays (or in those instances where the subscriber to or participant in the plan pays premiums on behalf of a Medicare eligible spouse or dependent, the amount the subscriber or participant pays).
- If plan enrollees are entitled to a reduction of their premium as Part D LIS enrollees and Humana receives a Low-Income Premium Subsidy for such enrollees, Humana will pass the Low-Income Premium Subsidy amount through to the LIS enrollees to reduce their premiums.

Dated on: _____ (month, date, year)

By: _____ (plan sponsor signature)

Dated at: _____ (city and state)

Title: _____ (plan sponsor title)

Plan Sponsor Name: _____

Agent/Producer Information

Agency of Record

Name (print) _____

Tax ID _____

Address _____

City/State/Zip: _____

Writing Agent/Agent of Record

Name (print) _____

Social Security Number _____

As the Writing Agent/Producer, I acknowledge that I am responsible to meet with the group submitting this application in order to fully and accurately represent the terms and conditions of the benefits and services offered by the plan.

Writing Agent's Signature: _____ Date: _____