Humana.

REQUEST FOR QUOTE - LARGE GROUPS

If Group Data Summary sheet is not completed, no quote will be issued.

Company Name: _____

Effective Date Requested: _____ Address: _____

Current Contract Renewal Date _____ _____

SIC Code: _____

Acct. Executive: _____

Commission: _____

Broker: _____

EIN: _____

Groups with 51 Enrolled and up to 99 Enrolled	**Groups with 100+ Enrolled**
MUST provide ALL of the following	**MUST provide ALL of the following**
Requirements to quote:	Prior and Current Plan Summary of Benefits
Signed Humana Puerto Rico - Health Risk Review Form	Prior Month's Insurance Billing
Current Plan Summary of Benefits	*Current Census (Enrolled + Not Enrolled Specified)
*Current Census (Enrolled + Not Enrolled Specified)	Monthly Enrollment and Experience Reports (past 2 years)
Rate History by Coverage (past 2 years) and Renewals	Large Claim Reports (including diagnosis) for past 2 years
Requirements to suscribe:	**Requirements to suscribe:**
Prior Month's Insurance Billing	Rate History by Coverage (past 2 years) and Renewals

** Census MUST include age or date of birth, gender, tier and plan selection for each subscriber if currently in a dual offering and/or slice business!*

***** The Underwriting Department reserve the right to request additional information if necessary.***

Summary of Employees

Total Employees _____

Part-Time Employees _____

Employees in Waiting Period _____

Total Eligible _____

Waivers w/other Group Coverage _____

Waivers (no other coverage) _____

Total Enrolled _____

Cobra Enrollees (% of total enrolled) _____

Eligibility Guidelines

Minimum Hours Per Week

New Employees are Covered on 1st of month _____

following _____ days/months of employment.

Optional Dependents? ☐ Yes ☐ No

Employees/Dependents out of PR? ☐ Yes ☐ No

Are Retirees Covered? ☐ Yes ☐ No

If Yes, # _____ Pre-65

_____ 65 and over

Rate History

	Prior Year Rates	Current Rates	Renewal Rates	Current Employer Contributions **(%)**
Employee Only				
Employee + Spouse				
Employee + Child(ren)				
Employee + Family				

Carrier History

Carrier Name	Effective Date	Cancel Date	Type of Plan	Reason for Leaving

Current Funding Method Current Funding Method: Fully Insured Partially Self Funded Other

**Groups that are Currently Partially Self-Funded are required to submit all information listed above and specific, aggregate factors, and actual and renewa claims cost.

Comments _____

Please answer the following questions by click on the checkbox. Select "Y" for Yes or "N" for No for all eligible employees and dependents (including owners, partners, and all those on any type of continuation coverage). Please provide details to "Yes" answers in the space provided.

HEALTH RISK REVIEW

1. According to your personal knowledge and/or Human Resource file, have any employees or dependents to be covered been diagnosed or treated during the past 2 years for any of the following conditions:

Y	N		Y	N		Y	N	
☐	☐	Heart Disorder	☐	☐	Stroke	☐	☐	Diabetes
☐	☐	Epilepsy or Seizures	☐	☐	Kidney Disease/Kidney Failure	☐	☐	Back, Neck Or Joint Disorder
☐	☐	Lung/Respiratory Disorder	☐	☐	Cancer or Tumors	☐	☐	AIDS, HIV, ARC, or HTLV
☐	☐	Drug or Alcohol Abuse	☐	☐	Mental or Nervous Disorder	☐	☐	Muscular Dystrophy
☐	☐	Congenital Disorders	☐	☐	Growth Hormones	☐	☐	Stomach/Intestinal Disorders
☐	☐	Liver Disorder	☐	☐	Organ Transplants	☐	☐	Any other medical disorder(s)
☐	☐	Spinal Muscular Atrophy	☐	☐	Hemophilia	☐	☐	Hepatitis

Y	N	
☐	☐	2. Are any of the employees or dependents to be covered currently pregnant? If so, list the expected delivery date, and any complications including the anticipation of multiple births.
☐	☐	3. Have any of the employees or dependents to be covered been hospitalized or had surgery during the past 5 years, or is any hospitalization or surgery anticipated in the next 12 months?
☐	☐	4. According to company records, have any employees to be covered been absent from work, confined to the home, or incapacitated for more than 2 consecutive weeks due to illness or injury during the past 2 years?
☐	☐	5. Have any of the employees or dependents to be covered been advised to undergo medical treatment or diagnostic testing in the next 6 months?
☐	☐	6. Are any employees or dependents to be covered receiving disability benefits of any type including Social Security Income,Worker's Compensation, Medicare, Medicaid, SINOT, or Fondo del Seguro del Estado?
☐	☐	7. Are there any employees or dependents to be covered who are incapacitated, currently hospitalized or confined to a treatment facility?
☐	☐	8. Does any employee or dependent to be covered anticipate a medical leave of absence for any reason?

.

Question Number	Employee or Dependent (Circle One)		Age	Medical Condition	Dates of Treatment	Name of Medication	$ Amount of Claims	Degree of Recovery
	Employee ☐	Dependent ☐						
	Employee ☐	Dependent ☐						
	Employee ☐	Dependent ☐						
	Employee ☐	Dependent ☐						
	Employee ☐	Dependent ☐						

IMPORTANT INFORMATION - PLEASE READ CAREFULLY

ANTI-FRAUD LAW

According to the dispositions of the Law Núm.18 of January 8 of 2004, we advise that the Article 27,320 of the Code of Insurances of Puerto Rico arrange the following: Any person who, knowingly and with the intend to defraud, presents false information in an insurance request form, or who presents a fraudulent claim for the payment of a loss, will incur a felony, and upon a conviction will be penalized for each violation with a fine no less than five thousand ($5,000) dollars nor more than ten thousand ($10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed establishment imprisonment may be increase to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.The non-compliance of the dispositions of this Article will include the imposition of an administrative fine no less than one thousand ($1,000) dollars nor more than five thousand ($5,000) dollars.

The information provided on this application is accurate and complete.I understand and agree that any omissions or incorrect statements made on this application may void or rescind coverage, or alter rates. I understand that coverage will become effective only on the date specified by Humana after the application has been approved by Humana and after the first full premium has been paid. By signing this form, I hereby Certify that all the information provided is true and correct.

Signature of Company Officer: _____ Print Name: _____

Title: _____ Date Signed: _____

Signature of Broker/Agent: _____ Print Name: _____

Title/Agency: _____ Date Signed: _____

Sales Representative: _____ Print Name: _____

Date Signed: _____