HUMANA®
Guidance when you need it most
1100 Employers Boulevard
Green Bay, WI 54344
Toll-Free: 800-558-4444

FULL-TIME EMPLOYMENT QUESTIONNAIRE

This form is needed to determine if an employee is in fact working the required number of hours and receiving adequate compensation for eligibility under the group plan. The form must be completed and signed by the employer.

Group Name _____ Group # _____

Name of Applicant _____ Date of Birth _____

Resident Address _____

Date Employed _____ Position _____ S.S.# _____

Hours actively-at-work per week for this employer _____ Number of weeks per year _____

Description of Duties _____

_____

Annual income from this employer as reported for Withholding Tax _____

Is this employee covered by Employer's Workers' Compensation coverage? _____

If not, please explain _____

OTHER OCCUPATIONS FOR WHICH APPLICANT RECEIVED SALARY OR EARNINGS:

Company _____ Weekly Hours Worked _____

Position _____ Income _____

Duties _____

_____

Additional Comments: _____

_____

_____

I hereby certify that the above statements are true and completed to the best of my knowledge. I understand that any misrepresentation contained herein relied on by the Company may be used to reduce or deny a claim or void the contract within the contestable period if such misrepresentation materially affects the acceptance of the risk.

_____
Employer's Legal Name

_____ by _____
Date Name

_____
Title