Eligibility Certification Form

HUMANA
Guidance when you need it most

This Eligibility Certification form and your most recent state wage and tax report (State Quarterly Report) will be used by Humana to determine if your company and employees satisfy your plan's participation and eligibility requirements.

Employer details

Renewal date

Employer name

Group number

Employer address

Employee name

Please list below all individuals who meet the following conditions, regardless of whether they are to be considered for coverage under your group plan.

- Not listed on your most recent state wage and tax report, AND
  - Actively working for you OR
  - Not working, but currently covered on your group plan for any reason (i.e. state or federal continuation, disability, etc)

Status code

Please use the following letter codes to indicate status

SP Sole proprietor (maximum of one person from this category may be eligible for coverage). Must be actively employed at this company.

OWN Owner, not a sole proprietor. Must be actively employed at this company.

PAR Partner. Must be actively employed at this company.

FT Full-time

PT Part-time

TM Temporary or seasonal employee (working less than 48 weeks per year)

TD Totally disabled

RE Retired Employee

CO Covered through state or federal continuation of coverage (COBRA)

WP Waiting period

How paid

H Hourly

S Salary

L Leased

CO Commissioned/contracted

O Other (please specify)

NA Not applicable (i.e. COBRA, retired, totally disabled, etc.)

Employee name	Date of employment	Hours worked per week	Status code	How paid
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

If additional space is needed, please attach additional pages. Additional pages must be signed and dated.

A waiver form will be required for employees and their dependents who are waiving any of the coverages available under your plan.

- I hereby certify that I have read this document and that the information provided is accurate and complete.
- I certify that all employees actively working for me are compensated in a manner that complies with all applicable federal and state minimum wage requirements.
- I certify that the information provided can be substantiated by business documents. Upon request, I agree to provide the documentation requested to establish eligibility and that participation requirements are met at all times coverage is provided by Humana (i.e. Wage and Tax form, Taxpayer I.D. numbers, W-2 forms, etc.)
- I understand that providing incomplete, inaccurate or untimely information may void, reduce or terminate any individual or group coverage or result in an increase in premium.

Signature of Employer_____ Date_____
(Owner, Officer, Partner)

Print name of Employer_____ Title _____

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Employer name: _____

Employee name	Date of employment	Hours worked per week	Status code	How paid
11				
12				
13				
14				
15				
16				
17				
18				
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