Employer Group Application (all group sizes)

Humana®

ILLINOIS

Humana.com

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in this Employer Group Application as "Humana", "We", "Us", or "Our".

HMO plans offered by **Humana Health Plan, Inc.** PPO, Indemnity medical and Life plans insured or administered by **Humana Insurance Company.** Dental PPO, Preventative Plus and Traditional Preferred plans insured or administered by **Humana Insurance Company**. Dental prepaid plans offered and administered by **CompBenefits Dental, Inc.The Dental Concern, Inc.** Vision plans insured or administered by **Humana Insurance Company**.

1. GROUP INFORMATION – Please type or print clearly in black ink

Group number:				
Group name:				Requested effective date __/__/____
Corporate/Situs location street address:	City:	State:	ZIP code:	County:
Date company established (MM/DD/YYYY):	Federal Tax ID:	Nature of business/SIC code:	Phone number:	
Benefit Administrator/management contact name:				
Phone number:	Email address:			
Billing contact name:				
Billing address (N/A if same as street address):	City:	State:	ZIP code:	
Phone number:	Email address:			
Are separate divisions/classes required for billing or reporting? ☐ No ☐ Yes If yes, please explain. Attach additional signed and dated sheets, if necessary.				
Wellness Program contact name:				
Phone number:	Email address:			

2. ELIGIBILITY REQUIREMENTS

Average total number of employees ☐	This means the average number of employees for the preceding calendar year. An employee is typically any person for which the company issues a W-2, regardless of full-time, part-time or seasonal status or whether or not they have medical coverage.
Average number of full-time equivalent employees ☐	For all employees included in the average total number of employees (above), calculate the average number of full-time equivalents for the preceding calendar year. The monthly full-time equivalents are calculated as follows: • number of **full-time employees** (who worked 30 hours or more per week on average); plus • total number of hours worked by **part-time employees** during the month capped at 120 hours, divided by 120

Eligible employee count (including those employees who waive coverage):	**Medical**	**Dental**	**Vision**	**Life**

Are you offering coverage to retirees (Non-Community Rated Medical, Dental and Vision)? ☐ No ☐ Yes
Required age (minimum 50): Minimum years of service:

Number of retirees to be covered:	**Medical:**	**Dental:**	**Vision:**

Does this company have any subsidiaries or affiliates, or are there any other associated entities that are eligible to file a federal or state combined tax return? ☐ No ☐ Yes If yes, enter information below:

Company name	**Total employees**

Probationary waiting period for eligible employees: ☐ 0 days ☐ 30 days ☐ 60 days ☐ 90 days ☐ Other: _____
If you prefer months, please select "Other" and specify the number of months.
Medical probationary waiting period must not exceed 90 days. HMO plans requiring referrals must not exceed 60 days.

Employee effective provision (the employee termination date coincides with the effective date provision):
☐ First of the month following probationary waiting period (required for HMO plans requiring referrals)
☐ Immediately following probationary waiting period (required for 90 day probationary waiting period)

Do you want to exclude a class of employees? ☐ No ☐ Yes
If yes, check class to exclude:
☐ Union ☐ Non-union ☐ Hourly ☐ Salary ☐ Management ☐ Non-management ☐ Other:

Is this a Collectively Bargained Plan? ☐ No ☐ Yes Name of plan _____
Plan number (assigned by employer for use in filing IRS form 5500):

Has this Group been insured by Humana within the last three years? ☐ No ☐ Yes
If yes, provide prior Group number: Termination date:

Do you wish to offer Domestic Partner coverage? ☐ No ☐ Yes

3. COBRA/STATE CONTINUATION

Is your Group subject to: COBRA ☐ No ☐ Yes State Continuation ☐ No ☐ Yes

Are any present or former employees/dependent currently on or eligible to elect COBRA/State Continuation? ☐ No ☐ Yes
If yes, enter information below. Attach additional signed and dated sheets (reorder IL-52660), if necessary.

Name of applicant	Qualifying event (e.g. termination of employment, divorce, etc)	Indicate if the applicant is currently on COBRA or State Continuation	COBRA/State Continuation			Lines of coverage (select all that apply)		
			Qualifying event date	Start date	End date	Medical	Dental	Vision
		☐ COBRA ☐ State Continuation				☐	☐	☐
		☐ COBRA ☐ State Continuation				☐	☐	☐
		☐ COBRA ☐ State Continuation				☐	☐	☐
		☐ COBRA ☐ State Continuation				☐	☐	☐

Plan Selection – Please review the Regulatory Pre-enrollment Disclosure Guide with your agent, broker or producer. Complete the quote number and reference number (if applicable) to indicate the plans elected.

4. MEDICAL PLAN SELECTION ☐ Electing ☐ Not electing

As an authorized representative of the Group, by signing this Employer Group Application, you hereby attest and acknowledge on behalf of the Group that you have agreed to deliver and have delivered to all participants of the Humana medical plan(s) the Summary of Benefits and Coverage (SBC) document(s) prior to the desired plan(s) effective date. For information on the SBC regulations and distribution requirements, please review the regulations at the HHS website: https://www.cms.gov/cciio/programs-and-initiatives/consumer-support-and-information/summary-of-benefits-and-coverage-and-uniform-glossary.html

Sold quote number: _____
Plan 1 name _____ / Reference # _____
Plan 2 name _____ / Reference # _____
Plan 3 name _____ / Reference # _____
Plan 4 name _____ / Reference # _____
Attach additional signed and dated sheets (found at the end of this form), if necessary.

Additional Product Selections (available for all group sizes). Employer election form must be completed.
☐ Health Care Flexible Spending Account (FSA) ☐ Dependent Care Flexible Spending Account (DCFSA) ☐ Health Savings Account (HSA)
☐ Health Reimbursement Arrangement (HRA)

Do you offer a supplemental medical plan that partially or completely subsidizes any member cost-sharing including, but not limited to, deductible, coinsurance, or co-pays and/or have purchased or created a funding mechanism which will fund an Employee Spending Account at a level that exceeds 30% of the plan deductible? ☐ No ☐ Yes If yes, indicate amount funded $_____

EMPLOYER CONTRIBUTION (Percentage or dollar amount): Minimum employer contribution toward employee premium is [0]% or $[0].
Employee: Employee/Spouse: Employee/Child: Family:

Participation – Available to employers with one or more enrolled employees and • Non-contributory - 100 % • Contributory - 25%	Number of employees waiving with other qualifying coverage:	Number of employees waiving without other qualifying coverage:	Number of employees enrolled:

Small Employer Participation Requirement

If the Group is a partnership as defined under state law, medical coverage is available if the Group has at least one common law employee who will be enrolled in the medical coverage or one bona fide partner who provides services on behalf of the partnership who will be enrolled in the medical coverage.

If the Group is not a partnership as defined under state law and the Group is considered to be wholly owned by one individual or one individual and his or her spouse, medical coverage is available only if the Group has at least one common law employee who is not the owner or a legally recognized spouse of the owner who will be enrolled in the medical coverage.

By signing this Employer Group Application, you, the authorized representative of the Group, understand, agree and represent:

1. You have read this Small Employer Participation Requirement and the Group satisfies the participation requirement stated above, which can be substantiated by the Group's records.
2. For the Group to remain eligible for medical coverage, the Group must satisfy the participation requirement stated above at all times. If at any time the Group does not satisfy the participation requirement, Humana may terminate the Group's medical coverage.

5. HEALTH QUESTIONNAIRE (for Non-Community Rated groups):

1.	Are there any disabled dependents over the age of 26 to be covered in this Group? If yes, please provide on a separate sheet of paper (form# IL-52662): name of employee, dependent name, statement of disability/ diagnosis from attending physician, dependency statement from employee and the name of the current group carrier insuring the dependent.	☐ No ☐ Yes
2.	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
3.	Is any employee presently not performing his or her duties on a full-time basis due to an illness or injury?	☐ No ☐ Yes
4.	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 $25,000 of medical expenses in the past 12 months • who has been advised within the last 90 days to have surgery or be hospitalized • who is eligible for and/or covered by Medicare related to a disability or End-Stage Renal Disease	 ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes
5.	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 who has been diagnosed, medically diagnosed or treated by a physician, or an appropriately licensed clinical professional acting within the scope of his/her license, for AIDS or an AIDS-related complex?	
6.	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 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:	
7.	Does your company currently sponsor short or long term disability? If yes, are any employees currently receiving benefits? Please indicate:	☐ No ☐ Yes

Coronary artery disease, chest pain, heart surgery, or any disease of the arteries, or blood disorders; hemophilia	☐ No ☐ Yes	Diabetes or any disease or disorder of the kidneys, liver or lungs	☐ No ☐ Yes
Stroke; Transient Ischemic Attack (TIA)	☐ No ☐ Yes	Systemic disease including, but not limited to Lupus, Multiple Sclerosis or Multiple Dystrophy	☐ No ☐ Yes
Cancer, and/or cancerous tumor; including skin cancer	☐ No ☐ Yes	Alcohol or drug abuse or dependence, or psychological disorder	☐ No ☐ Yes
Stomach, gall bladder, digestive, intestinal, or colon disorders	☐ No ☐ Yes	Organ transplant (other than corneal)	☐ No ☐ Yes

If you answered yes to questions 2-6 above, please indicate the question number and explanation. Attach additional signed and dated sheets (IL-52661), if necessary.

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 R=Retiree

6. DENTAL PLAN SELECTION ☐ Electing ☐ Not electing

Sold quote number: _____

Plan 1 name _____ / Reference # _____

Plan 2 name _____ / Reference # _____

Plan 3 name _____ / Reference # _____

Attach additional signed and dated sheets (found at the end of this form), if necessary.

EMPLOYER CONTRIBUTION (Percentage or dollar amount): Minimum employer contribution toward employee premium is [0]% or $[0].
Employee: Employee/Spouse: Employee/Child: Family:

Participation - Available to employers with 1 or more enrolled employees and • Non-Contributory plan – 100% • Contributory plan – 50% • Voluntary plan – minimum of 2 enrolled	Number of employees waiving with other qualifying coverage:	Number of employees waiving without other qualifying coverage:	Number of employees enrolled:

CURRENT CARRIER
Is this Group transferring group dental coverage from another group carrier? ☐ No ☐ Yes
Does prior coverage include orthodontia? ☐ No ☐ Yes

If yes, provide carrier name: _____ Proposed termination date:_____

7. VISION PLAN SELECTION ☐ Electing ☐ Not electing

Sold quote number: _____

Plan 1 name _____ / Reference # _____

Plan 2 name _____ / Reference # _____

Dual choice arrangements are subject to underwriting review.

EMPLOYER CONTRIBUTION (Percentage or dollar amount): Minimum employer contribution toward employee premium is [0]% or $[0].
Employee: Employee/Spouse: Employee/Child: Family:

Participation - Available to employers with: • 1 or more enrolled employees when sold with medical and/or dental; • 5 or more enrolled when standalone; and • Non-Contributory plan – 100% • Contributory plan – 50% • Voluntary plan – minimum of 5 enrolled	Number of employees waiving with other qualifying coverage:	Number of employees waiving without other qualifying coverage:	Number of employees enrolled:

8. LIFE PLAN SELECTION

Sold quote number: _____ Reference # _____

Basic Life and AD&D: ☐ Electing ☐ Not electing

EMPLOYER CONTRIBUTION (Percentage or dollar amount) for **BASIC** Employee and Dependent Life **ONLY**): Minimum employer contribution toward employee premium is 100%.

Employee: Employee/Spouse: Employee/Child: Family:

Participation Requirement - Available to employers with two or more enrolled employees.
• Non-contributory plan - 100% • Contributory plan - 50%

Number of hours worked per week to be eligible (select between 20 and 40 hours):

CURRENT CARRIER
Is this Group transferring group life coverage from another group carrier?: ☐ No ☐ Yes

If yes, provide carrier name: Proposed termination date:

As of the date of this application, list any employees currently disabled and not actively at work (attach additional signed and dated pages, if necessary):

Rate Guarantee: ☐ 2 Year ☐ 3 Year
Age Reduction Schedule: ☐ Schedule 1 ☐ Schedule 2 ☐ Schedule 3
☐ Flat amount $ _____
☐ Salary plan – options are 1x to 7x salary (in .5 increments), rounded to the next highest $1,000
Salary level: ____ x salary Maximum benefit: $_____
☐ Class schedule – no more than 2.5x between classes and 10x between the lowest and highest class. Complete the table below.

Class	Description	Flat amount or Salary level
1		
2		
3		
4		

Basic Dependent Life: ☐ Electing ☐ Not electing
If yes, indicate volume amount ☐ $20,000/ $5,000 ☐ $10,000/ $2,500 ☐ $5,000/$1,000

Voluntary Employee Life: ☐ Electing ☐ Not electing Reference # _____
Available to employers with five or more or 25% of the eligible employees enrolled, whichever is greater.

Do you want AD&D? ☐ No ☐ Yes
Rate Guarantee: ☐ 2 Year ☐ 3 Year
Age Reduction Schedule (Basic and Voluntary Age Reduction Schedules must match): ☐ Schedule 1 ☐ Schedule 2 ☐ Schedule 3

☐ Minimum amount $_____ ☐ Maximum benefit $_____

Voluntary Dependent Life (only available if Employee Voluntary Life is elected) ☐ No ☐ Yes
Dependent Child Voluntary Amount ☐ $5,000 ☐ $10,000

9. THE FOLLOWING APPLIES TO ALL GROUPS SUBJECT TO ERISA

As claims administrator with authority to make claim determinations as described in Section 503 of the Employee Retirement Income Security Act (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, the participating employer, policyholder, contract holder, or Certificate sponsor, intend to establish, sponsor, plan sponsor and endorse an employee benefit plan which will be governed by ERISA. You are the ERISA plan administrator.

10. THE FOLLOWING APPLIES TO ALL GROUPS

The Group is only eligible if a bona fide business entity exists.

If you fail to pay premium when due, coverage may be subject to termination as specified under the terms of the Policy. You understand and agree that your coverage is continued monthly 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. You will receive advance written notice.

You will provide information or records upon request that We determine are relevant to this Employer Group Application and group coverage for inspection by Us or Our representative. For you to remain eligible you must meet the eligibility, participation and contribution requirements for each respective coverage at all times.

We have the right to use information provided by you to determine whether this Employer Group Application will be accepted or declined and to establish appropriate premiums.

For Non-Community Rated medical plans, Humana reserves the right to recalculate the rates if final enrollment/participation due to demographic changes which are due to age, sex, coverage type, geographic area, that, in the aggregate, would impact premium more than 5%. For all other plans, Humana reserves the right to recalculate the rates based on final enrollment/participation.

11. AGREEMENT AND SIGNATURE – Review your policy/certificate carefully

You, the authorized representative of the Group named herein, understand, agree and represent: You have read this Employer Group Application and the information you provided is accurate and complete and can be substantiated by your records. You have received and reviewed the applicable regulatory information and the Humana issued proposal. You referred to the proposal to select the benefit plan(s) applied for in this Employer Group Application and confirmed your selection from the Humana issued proposal before signing below. By executing this Employer Group Application, you agree to its terms and represent and warrant that you shall comply with the terms of the Policy and all applicable laws. An act of fraud or an intentional misrepresentation of a material fact may void or terminate an individual's or Group's coverage as specified under the terms of the Policy or Certificate. We shall rely on your representations and any information submitted by you or on your behalf. Providing incomplete, inaccurate or untimely information may reduce an individual's or Group's coverage or may increase past premium. In addition, any person who knowingly presents false information in an application for insurance or life settlement contract is guilty of a crime and, upon conviction, may be subject to fines or confinement in prison, or both.

Coverage is not in effect unless and until you receive written notification from Us. The Employer Group Application will form part of any contract or coverage issued. The original version of this Agreement is in the English language. If there are any discrepancies or conflicts between the English and any other version that has been translated into another language, the English version will control. Neither you nor the agent 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.

DO NOT CANCEL ANY CURRENT GROUP COVERAGE UNTIL YOU RECEIVE WRITTEN NOTICE FROM US THAT WE HAVE ISSUED COVERAGE.

Dated on: _____ by: _____
(month, day, year) (Printed name of authorized representative of Group)

Signature:_____ Title: _____

12. AGENT INFORMATION

Agency of Record (for commissions and correspondence)	**Agent/Agency of Record** (for split commissions)
Name (print or type)	Name (print or type)
Tax ID/Social Security Number/Humana Agent Number	Tax ID/Social Security Number/Humana Agent Number
Commission split ☐ No ☐ Yes If yes, percentage: _____ (equals 100%)	Commission split ☐ No ☐ Yes If yes, percentage: _____ (equals 100%)
Writing Agent/Broker Producer	**Agent/Agency of Record**
Name (print or type)	Name (print or type)
Tax ID/Social Security Number/Humana Agent Number	Tax ID/Social Security Number/Humana Agent Number
Commission split ☐ No ☐ Yes If yes, percentage: _____ (equals 100%)	Commission split ☐ No ☐ Yes If yes, percentage: _____ (equals 100%)

General Agency (Complete only if agency involved in sale)

General agency information pertains to: ☐ Agency of Record ☐ Writing Agent	
Name (print or type)	Tax ID/Social Security Number/Humana Agent Number

As the Agent, I acknowledge that I am responsible to meet with the Group submitting this Employer Group 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 Group in the Regulatory Pre-enrollment Disclosure Guide or other plan literature. Additionally, I acknowledge that I am responsible for providing the Group a copy of their completed and signed Employer Group Application.

Writing Agent signature: _____ Date: _____

Employer Group Application

Humana.

ADDITIONAL PLAN SELECTION – Medical and Dental

Please complete this form and return with IL-52657 to elect additional plan options for the group. Humana.com

Medical Plan Selection

Plan 5 Name _____	/ Reference # _____
Plan 6 Name _____	/ Reference # _____
Plan 7 Name _____	/ Reference # _____
Plan 8 Name _____	/ Reference # _____
Plan 9 Name _____	/ Reference # _____
Plan 10 Name _____	/ Reference # _____
If Private Exchange, please continue below	**Option A** ____ **Option B** ____ **Option C** ____
Plan 11 Name _____	/ Reference # _____
Plan 12 Name _____	/ Reference # _____
Plan 13 Name _____	/ Reference # _____
Plan 14 Name _____	/ Reference # _____
Plan 15 Name _____	/ Reference # _____
Plan 16 Name _____	/ Reference # _____
Plan 17 Name _____	/ Reference # _____
Plan 18 Name _____	/ Reference # _____
Plan 19 Name _____	/ Reference # _____
Plan 20 Name _____	/ Reference # _____
Plan 21 Name _____	/ Reference # _____
Plan 22 Name _____	/ Reference # _____
Plan 23 Name _____	/ Reference # _____
Plan 24 Name _____	/ Reference # _____
Plan 25 Name _____	/ Reference # _____

Dental Plan Selection

Plan 4 Name _____	/ Reference # _____
Plan 5 Name _____	/ Reference # _____
Plan 6 Name _____	/ Reference # _____

By _____ _____ _____

Group authorized representative (Printed name) (Signature) (Date)

HMO plans offered by **Humana Health Plan, Inc**. PPO and Indemnity Medical plans insured or administered by **Humana Insurance Company**. Dental PPO, Preventative Plus, and Traditional Preferred plans insured or administered by **Humana Insurance Company**. Dental prepaid plans offered and administered by **CompBenefits Dental, Inc**. **The Dental Concern, Inc.** Vision plans insured or administered by **Humana Insurance Company**.

Employer Group Application

Humana.

COBRA/STATE CONTINUATION ADDITIONAL INFORMATION

Please complete this form and return with IL-52657 for additional COBRA/State Continuation information. Humana.com

Name of applicant	Qualifying event (e.g. termination of employment, divorce, etc)	Indicate if the applicant is currently on COBRA or State Continuation	COBRA/State Continuation			Lines of coverage (select all that apply)		
			Qualifying event date	Start date	End date	Medical	Dental	Vision
		☐ COBRA ☐ State Continuation				☐	☐	☐
		☐ COBRA ☐ State Continuation				☐	☐	☐
		☐ COBRA ☐ State Continuation				☐	☐	☐
		☐ COBRA ☐ State Continuation				☐	☐	☐
		☐ COBRA ☐ State Continuation				☐	☐	☐
		☐ COBRA ☐ State Continuation				☐	☐	☐
		☐ COBRA ☐ State Continuation				☐	☐	☐
		☐ COBRA ☐ State Continuation				☐	☐	☐
		☐ COBRA ☐ State Continuation				☐	☐	☐
		☐ COBRA ☐ State Continuation				☐	☐	☐
		☐ COBRA ☐ State Continuation				☐	☐	☐
		☐ COBRA ☐ State Continuation				☐	☐	☐
		☐ COBRA ☐ State Continuation				☐	☐	☐
		☐ COBRA ☐ State Continuation				☐	☐	☐
		☐ COBRA ☐ State Continuation				☐	☐	☐
		☐ COBRA ☐ State Continuation				☐	☐	☐
		☐ COBRA ☐ State Continuation				☐	☐	☐
		☐ COBRA ☐ State Continuation				☐	☐	☐

By ____ ____ ____________________
Group authorized representative (Printed name) (Signature) (Date)

HMO plans offered by **Humana Health Plan, Inc**. PPO and Indemnity Medical plans insured or administered by **Humana Insurance Company**. Dental PPO, Preventative Plus, and Traditional Preferred plans insured or administered by **Humana Insurance Company**. Dental prepaid plans offered and administered by **CompBenefits Dental, Inc**. **The Dental Concern, Inc.** Vision plans insured or administered by **Humana Insurance Company**.

Employer Group Application

Humana.

DISABLED DEPENDENTS OVER THE AGE OF 26

Please complete this form and return with IL-52657 for information regarding Disabled Dependents. Humana.com

Employee name	Dependent name	Statement of disability/diagnosis from attending physician attached? (If no, indicate reason below)		Dependency statement from employee	Current group carrier insuring dependent
		☐ Yes ☐ No			
		☐ Yes ☐ No			
		☐ Yes ☐ No			
		☐ Yes ☐ No			
		☐ Yes ☐ No			
		☐ Yes ☐ No			
		☐ Yes ☐ No			
		☐ Yes ☐ No			
		☐ Yes ☐ No			
		☐ Yes ☐ No			
		☐ Yes ☐ No			
		☐ Yes ☐ No			
		☐ Yes ☐ No			
		☐ Yes ☐ No			
		☐ Yes ☐ No			
		☐ Yes ☐ No			
		☐ Yes ☐ No			
		☐ Yes ☐ No			
		☐ Yes ☐ No			

By _____ _____ _____

Group authorized representative (Printed name) (Signature) (Date)

HMO plans offered by **Humana Health Plan, Inc**. PPO and Indemnity Medical plans insured or administered by **Humana Insurance Company**. Dental PPO, Preventative Plus, and Traditional Preferred plans insured or administered by **Humana Insurance Company**. Dental prepaid plans offered and administered by **CompBenefits Dental, Inc**. **The Dental Concern, Inc.** Vision plans insured or administered by **Humana Insurance Company**.