

Humana Employee Change Form

Please print clearly and fill in each applicable circle.

Current Group number _____ Benefit number _____ Class/Division _____
Company name _____ Proposed Effective Date for change: ___ / ___ / _____
Company city _____ State _____

Employee Information and Changes

Please provide employee information and indicate all applicable employee changes.

Last name _____ First name _____ MI _____ Social Security number _____

Change medical benefit/class to: Benefit number: _____ Class/Division: _____

Change or Select Employee Primary Care Physician (HMO and POS only):

Primary care physician: _____ Physician ID: _____

Change dental benefit/class to: Benefit number: _____ Class/Division: _____

Change or Select Employee Primary Care Dentist (applicable to AZ, CA, FL, IL, and TX only):

Primary dentist: _____ Facility number: _____

Change basic life benefit/class to: Benefit number: _____ Class/Division: _____

Change beneficiary:

Basic Life: Group number: _____

Primary beneficiary name: _____ Secondary beneficiary name: _____

Voluntary Life: Group number: _____

Primary beneficiary name: _____ Secondary beneficiary name: _____

Cancel my coverage for the following products: Medical Dental Basic Life Voluntary Life Short-term Income Protection
 Health Savings Account (HSA) Health Care FSA Dependent Care FSA

Qualifying Event Information

Please indicate the qualifying event date and reason for employee or dependent changes below.

Qualifying event date: ___ / ___ / _____

Reason for change:

- | | | |
|----------------------------------------------------|-------------------------------------------------------------|-----------------------------------------------------------------------------|
| <input type="radio"/> Re-hire | <input type="radio"/> Divorce | <input type="radio"/> Spouse changes from full-time to part-time employment |
| <input type="radio"/> Employer contribution ceases | <input type="radio"/> Spouse deceased | <input type="radio"/> Other: _____ |
| <input type="radio"/> Dependent birth / adoption | <input type="radio"/> Spouse terminates employment | |
| <input type="radio"/> Legal separation | <input type="radio"/> Spouse's employer terminates coverage | |

Change Address Information

Address change applies to:

- Employee only Employee and all covered dependents
 Only for the following dependents (please print full name): _____

New street address _____ Apt / Suite / PO Box number _____
City _____ State _____ Zip code _____ County _____
Email address _____ Phone number _____

Group Number

Social Security Number

Dependent Changes

Please complete this section for all dependent changes.

1 Last name _____ First name _____ MI _____ Date of birth _____
 Social Security number _____ Gender: Female Male Relationship: Spouse Child Other: _____
 Dependent status (if applicable): Full-time student Disabled If disabled, indicate reason: _____
 Add or **Delete** dependent to/from my current plan for the following products: Medical Dental Basic Life Voluntary Life
 Change or Select Primary Care Physician (HMO and POS only):
 Primary care physician: _____ Physician ID: _____
 Change or Select DHMO (applicable to AZ, CA, FL, IL, and TX only):
 Primary dentist: _____ Facility number: _____

2 Last name _____ First name _____ MI _____ Date of birth _____
 Social Security number _____ Gender: Female Male Relationship: Spouse Child Other: _____
 Dependent status (if applicable): Full-time student Disabled If disabled, indicate reason: _____
 Add or **Delete** dependent to/from my current plan for the following products: Medical Dental Basic Life Voluntary Life
 Change or Select Primary Care Physician (HMO and POS only):
 Primary care physician: _____ Physician ID: _____
 Change or Select DHMO (applicable to AZ, CA, FL, IL, and TX only):
 Primary dentist: _____ Facility number: _____

3 Last name _____ First name _____ MI _____ Date of birth _____
 Social Security number _____ Gender: Female Male Relationship: Spouse Child Other: _____
 Dependent status (if applicable): Full-time student Disabled If disabled, indicate reason: _____
 Add or **Delete** dependent to/from my current plan for the following products: Medical Dental Basic Life Voluntary Life
 Change or Select Primary Care Physician (HMO and POS only):
 Primary care physician: _____ Physician ID: _____
 Change or Select DHMO (applicable to AZ, CA, FL, IL, and TX only):
 Primary dentist: _____ Facility number: _____

4 Last name _____ First name _____ MI _____ Date of birth _____
 Social Security number _____ Gender: Female Male Relationship: Spouse Child Other: _____
 Dependent status (if applicable): Full-time student Disabled If disabled, indicate reason: _____
 Add or **Delete** dependent to/from my current plan for the following products: Medical Dental Basic Life Voluntary Life
 Change or Select Primary Care Physician (HMO and POS only):
 Primary care physician: _____ Physician ID: _____
 Change or Select DHMO (applicable to AZ, CA, FL, IL, and TX only):
 Primary dentist: _____ Facility number: _____

Signature - please sign below if requesting changes

Employee or legal representative signature: _____ Date: _____

Name and relationship of legal representative: _____