Print Form

Humana Employee Change Form

Please print clearly and fill in each applicable circle.

Group number

Proposed Effective Date for change: __ __ / __ __ / __ __ __ __

Company name | 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 Basic Life Beneficiary:** Group number: _____
    Primary beneficiary name: Last name First name MI
    Secondary beneficiary name: Last name First name MI
  - ○ **Change Voluntary Life Beneficiary:** Group number: _____
    Primary beneficiary name: Last name First name MI
    Secondary beneficiary name: Last name First name MI
- ○ **Change Vision benefit/class to:** Benefit number: _____ Class/Division: _____
- ○ **Cancel My Coverage** for the following products: ○ Medical ○ Dental ○ Basic Life ○ Voluntary Life ○ Short-term Income Protection ○ Vision ○ 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:

- ○ Re-hire
- ○ Employer contribution ceases
- ○ Dependent birth / adoption
- ○ Dependent change to full-time student
- ○ Marriage
- ○ Legal separation
- ○ Divorce
- ○ Spouse deceased
- ○ Spouse terminates employment
- ○ Spouse's employer terminates coverage
- ○ Spouse changes from full-time to part-time employment
- ○ Other: _____

Change Address Information

Address change applies to:

○ Employee only ○ Employee and all covered dependents

○ Only for the following dependent (please print full name): Last name First name MI

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 ○ Vision

○ **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 ○ Vision

○ **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 ○ Vision

○ **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 ○ Vision

○ **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: _____