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

Primary dentist: _____ Facility number: _____

❍ **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:

❍ Re-hire
❍ Employer contribution ceases
❍ Dependent birth / adoption
❍ 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 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: _____