Humana Employee Chan	ige Form					
Please print clearly and fill in each a	pplicable circle.					
Current Medical Group number		Benefit number		Class/Division		
Current Dental Group number		Proposed Effective	e Date for change:	/ /		
Company name		Company city		State		
Employee Information and Cha	anges					
Please provide employee information and in	ndicate all applicable e	employee changes.				
Last name	First name	MI	Social Security numb	er		
O Change Medical benefit/class to: Ben	nefit number:		Class/Division:			
O Change or Select Employee Prir	mary Care Physician (HMO and POS only):				
Primary care physician:			Physician ID:			
O Change Dental benefit/class to: Bene	efit number:		Class/Division:			
O Change or Select Employee Prir	nary Care Dentist (ap	plicable to AL, AZ, CA,	, FL, GA, IL, IN, KS, KY, N	ло, NC, OH, TN, TX and WV only)		
Primary dentist:			Facility numbe	r:		
O Change Basic Life benefit/class to: B						
O Change Basic Life Beneficiary:						
Primary beneficiary name: Last				MI		
Secondary beneficiary name: Last			F: .	MI		
• Change Voluntary Life Beneficia						
Primary beneficiary name: Last	•		First name	MI		
Secondary beneficiary name: Last			First name	MI		
O Change Vision benefit/class to: Bene			Class/Division:			
O Cancel My Coverage for the following p	oroducts: O Medical	O Dental O Basic L	ife 🔾 Voluntary Life 🤇	Short-term Income Protection		
	O Vision O	Health Savings Accou	unt (HSA) 🔾 Health Ca	are FSA O Dependent Care FSA		
Qualifying Event Information						
Please indicate the qualifying event date an	nd reason for employee	e or dependent chan	ges below.			
Qualifying event date: / /						
Reason for change:						
○ Re-hire	O Marriage		Spouse ter	minates employment		
• Employer contribution ceases	Legal separation	ı	○ Spouse's e	O Spouse's employer terminates coverage		
O Dependent birth / adoption	O Divorce		O Spouse ch	anges from full-time to		
O Dependent change to full-time student	Spouse decease	d	•	employment		
Change Address Information			Other			
Address change applies to:						
Employee only Employee and all cov	vered denendents					
Only for the following dependent (please	•	name	First nam	ne MI		
New street address	. print run name). Last i		Apt / Suite / PO Box nur			
City	State	Zip code	Cou			
Email address		Phone number				
		•				

Gro	oup Number	Social Securi	ty Number				
Dependent Changes							
Please complete this section for	all dependent changes.						
Last name	First name		MI	Date of birth	_//		
	Gender: O Female	O Male Relati	onship: O Spouse				
	: O Full-time student O Dis		abled, indicate reasor				
O Add or O Delete dependen	nt to/from my current plan for the	following products:	O Medical	O Dental	O Basic Life		
Change of Calast Drimon.	Care Physician (LIMO and DOC)	I. A.	O Voluntary Life	Vision			
	Care Physician (HMO and POS of		Dl	ID:			
	applicable to AL, AZ, CA, FL, GA, IL						
				-			
Primary dentist:		Facility number:					
Last name	First name		MI	Data of hirth	//		
Social Security number	Gender: O Female	O Malo Rolati	onship: O Spouse				
	: O Full-time student O Dis		abled, indicate reasor		ет.		
	nt to/from my current plan for the			O Dental	O Basic Life		
Add of S befere dependen	it to monthly current plan for the	Tollowing products.	O Voluntary Life		J busic life		
Change or Select Primary	Care Physician (HMO and POS o	only):					
Primary care physician:			Physicia	an ID:			
Change or Select DHMO (a	applicable to AL, AZ, CA, FL, GA, IL	., IN, KS, KY, MO, NC	, OH, TN, TX and WV	only):			
Primary dentist:	Facility number:						
Last name	First name		MI		_//		
Social Security number	Gender: O Female		onship: O Spouse		er:		
	: O Full-time student O Dis		abled, indicate reason		O D 1 116		
Add or O Delete depender	nt to/from my current plan for the	following products:	MedicalVoluntary Life	DentalVision	Basic Life		
Change or Select Primary	Care Physician (HMO and POS o	only):	,				
Primary care physician:			Physicia	an ID:			
Change or Select DHMO (a	applicable to AL, AZ, CA, FL, GA, IL	., IN, KS, KY, MO, NC	, OH, TN, TX and WV	only):			
Primary dentist:			Facility number:				
Last name	First name		MI	Date of birth _	//		
Social Security number	Gender: O Female	O Male Relati	onship: O Spouse	O Child O Oth	er:		
Dependent status (if applicable)	: O Full-time student O Dis	sabled If disa	abled, indicate reasor	า:			
Add or O Delete dependen	nt to/from my current plan for the	following products:	MedicalVoluntary Life	DentalVision	O Basic Life		
Change or Select Primary	Care Physician (HMO and POS o	only)·	• Voluntary Line	VISIOII			
		•	Physicia	an ID:			
	applicable to AL, AZ, CA, FL, GA, IL						
_	ppileable to 7.E, 7.E, C7, 1.E, G7, 1.E			number:			
·			raciity				
Signature - please sign be	ow if requesting changes						
mployee or legal representative s	ignature:			Date:			
ame and relationship of legal re।	presentative:						