Humana Employee Cha	nge Form				
Please print clearly and fill in each	applicable 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 Ch	anges				
Please provide employee information and	indicate all applicable e	employee changes.			
Last name	First name	MI	Social Security numb	er	
<b>O</b> Change Medical benefit/class to: B	enefit number:		Class/Division:		
○ Change or Select Employee Pr	imary Care Physician (	HMO and POS only):			
Primary care physician:			Physician ID:		
• Change Dental benefit/class to: Benefit number:			Class/Division:	_ Class/Division:	
○ Change or Select Employee Pr	imary Care Dentist (ap	plicable to AL, AZ, CA,	FL, GA, IL, IN, KS, KY, N	10, NC, OH, TN, TX and WV only):	
Primary dentist:			Facility number	r:	
• Change Basic Life benefit/class to:	Benefit number:		Class/Division:		
• Change Basic Life Beneficiary:	Group number:				
Primary beneficiary name: La	•		First name	MI	
Secondary beneficiary name: La	st name		First name	MI	
○ Change Voluntary Life Benefic	iary: Group number:				
Primary beneficiary name: La	st name		First name	MI	
Secondary beneficiary name: La	st name		First name	MI	
<b>O</b> Change Vision benefit/class to: Ben	efit number:		Class/Division:		
• Cancel My Coverage for the following	•			○ Short-term Income Protection are FSA ○ Dependent Care FSA	
Qualifying Event Information					
Please indicate the qualifying event date a	and reason for employe	e or dependent chan	ges below.		
Qualifying event date: / / /					
Reason for change:					
• Re-hire	• Marriage		• Spouse ter	minates employment	
<b>O</b> Employer contribution ceases	• Legal separation	n	○ Spouse's e	mployer terminates coverage	
O Dependent birth / adoption	• Divorce			anges from full-time to	
<b>O</b> Dependent change to full-time student	• Spouse decease	ed		employment	
Change Address Information					
Address change applies to:					
• Employee only • Employee and all co	overed dependents				
• Only for the following dependent (please	·	name	First nam	e MI	
New street address	· · ·		Apt / Suite / PO Box nun	nber	
City	State	Zip code	Cou	nty	
Email address		ŀ	Phone number		

	Grou	up Number Socia	al Security Number				
	Dependent Changes						
Ple	ease complete this section for a	all dependent changes.					
1	Last name	First name	MI	Date of birth//	_		
	Social Security number	Gender: 🔾 Female 🔾 Male	Relationship: O Spouse				
	Dependent status (if applicable):	• Full-time student • Disabled	If disabled, indicate reason:				
0	• Add or • Delete dependent	t to/from my current plan for the following pr	roducts: O Medical	O Dental O Basic Life			
0	) Change or Select Primary C	Care Physician (HMO and POS only):	○ Voluntary Life	O Vision			
	Primary care physician: Physician ID:						
$\circ$		oplicable to AL, AZ, CA, FL, GA, IL, IN, KS, KY,	-				
	-	Spincable to AL, AL, CA, TL, OA, IL, IN, K3, K1,					
				iumber			
2	Last name	First name	MI	Date of birth///			
	Social Security number	Gender: 🔾 Female 🔾 Male	Relationship: O Spouse 🤇				
	Dependent status (if applicable):	• Full-time student • Disabled	If disabled, indicate reason:				
0	• Add or • Delete dependent	t to/from my current plan for the following pr	roducts: <b>O</b> Medical	O Dental O Basic Life	1		
0	) Change or Select Primary C	Care Physician (HMO and POS only):	• Voluntary Life	O Vision			
	-		Physician	n ID:			
0		pplicable to AL, AZ, CA, FL, GA, IL, IN, KS, KY,					
				-			
			Tacinty II	amber			
3	Last name	First name	MI	Date of birth//	_		
	Social Security number	Gender: 🔾 Female 🔾 Male	Relationship: O Spouse 🤇	<b>O</b> Child <b>O</b> Other:			
	Dependent status (if applicable):	• Full-time student • Disabled	If disabled, indicate reason:				
0	• Add or • Delete dependent	t to/from my current plan for the following pr	roducts: O Medical O Voluntary Life	O Dental O Basic Life O Vision			
Q	) Change or Select Primary C	Care Physician (HMO and POS only):		VISION			
	-		Dhurdeler				
$\sim$			Physician	n II).			
	Change or Select DHMO (an	policable to AL AZ CA FL GA IL IN KS KY					
0		oplicable to AL, AZ, CA, FL, GA, IL, IN, KS, KY,	MO, NC, OH, TN, TX and WV o	nly):			
0			MO, NC, OH, TN, TX and WV o	nly):			
		oplicable to AL, AZ, CA, FL, GA, IL, IN, KS, KY,	MO, NC, OH, TN, TX and WV o	nly):			
4	Primary dentist:	oplicable to AL, AZ, CA, FL, GA, IL, IN, KS, KY,	MO, NC, OH, TN, TX and WV o Facility n MI	nly): iumber: Date of birth//			
4	Primary dentist: Last name Social Security number	pplicable to AL, AZ, CA, FL, GA, IL, IN, KS, KY,	MO, NC, OH, TN, TX and WV o Facility n MI	nly): number: Date of birth// O Child O Other:			
4	Primary dentist: Last name Social Security number Dependent status (if applicable):	First name Gender: O Female O Male Guil-time student O Disabled	MO, NC, OH, TN, TX and WV o Facility n MI Relationship: O Spouse C If disabled, indicate reason:	nly): number: Date of birth// O Child O Other:	_		
<b>4</b>	Primary dentist: Last name Social Security number Dependent status (if applicable): Add or O Delete dependent	First name Gender: O Female O Male Full-time student O Disabled t to/from my current plan for the following pr	MO, NC, OH, TN, TX and WV o Facility n MI Relationship: O Spouse C If disabled, indicate reason:	nly): number: Date of birth// O Child O Other:	_		
<b>4</b>	Primary dentist: Last name Social Security number Dependent status (if applicable): Add or O Delete dependent Change or Select Primary C	First name Gender: O Female O Male Full-time student O Disabled t to/from my current plan for the following pr Care Physician (HMO and POS only):	MO, NC, OH, TN, TX and WV o Facility n MI Relationship: O Spouse O If disabled, indicate reason: roducts: O Medical O Voluntary Life	Date of birth//   Date of birth//   O Child O Other:   O Dental   O Dental   O Vision	 		
<b>4</b>	Primary dentist: Last name Social Security number Dependent status (if applicable): Add or O Delete dependent O Change or Select Primary C Primary care physician:	First name Gender: O Female O Male First name Gender: O Female O Male Full-time student O Disabled t to/from my current plan for the following pr Care Physician (HMO and POS only):	MO, NC, OH, TN, TX and WV o Facility n MI Relationship: O Spouse C If disabled, indicate reason: roducts: O Medical O Voluntary Life Physiciar	nly): Date of birth// Date of birth// Child O Other: O Dental O Basic Life O Vision	 		
<b>4</b>	Primary dentist: Last name Social Security number Dependent status (if applicable): Add or O Delete dependent O Change or Select Primary C Primary care physician: O Change or Select DHMO (ap	First name Gender: O Female O Male Full-time student O Disabled t to/from my current plan for the following pr Care Physician (HMO and POS only):	MO, NC, OH, TN, TX and WV o Facility n MI Relationship: O Spouse O If disabled, indicate reason: roducts: O Medical O Voluntary Life Physiciar MO, NC, OH, TN, TX and WV o	nly): Date of birth/_// Date of birth/_// Child O Other: Dental O Basic Life Vision n ID: nly):			
<b>4</b>	Primary dentist: Last name Social Security number Dependent status (if applicable): Add or O Delete dependent O Change or Select Primary C Primary care physician: O Change or Select DHMO (ap Primary dentist:	First name Gender: O Female O Male First name Gender: O Female O Male Full-time student O Disabled t to/from my current plan for the following pr Care Physician (HMO and POS only):	MO, NC, OH, TN, TX and WV o Facility n MI Relationship: O Spouse O If disabled, indicate reason: roducts: O Medical O Voluntary Life Physiciar MO, NC, OH, TN, TX and WV o	nly): Date of birth/_// Date of birth/_// Child O Other: Dental O Basic Life Vision n ID: nly):			
	Primary dentist: Last name Social Security number Dependent status (if applicable): O Add or O Delete dependent O Change or Select Primary C Primary care physician: O Change or Select DHMO (application) Primary dentist: Signature - please sign belo	First name Gender: O Female O Male Gender: D Female O Male Full-time student O Disabled t to/from my current plan for the following pr Care Physician (HMO and POS only): pplicable to AL, AZ, CA, FL, GA, IL, IN, KS, KY, pow if requesting changes	MO, NC, OH, TN, TX and WV o Facility n MI Relationship: O Spouse O If disabled, indicate reason: roducts: O Medical O Voluntary Life Physiciar MO, NC, OH, TN, TX and WV o Facility n	nly): Date of birth/_// Date of birth/_// Child O Other: Dental O Basic Life Vision n ID: nly):			
	Primary dentist: Last name Social Security number Dependent status (if applicable): O Add or O Delete dependent O Change or Select Primary C Primary care physician: O Change or Select DHMO (application) Primary dentist: Signature - please sign belo	First name Gender: O Female O Male First name Gender: O Female O Male Full-time student O Disabled t to/from my current plan for the following pr Care Physician (HMO and POS only):	MO, NC, OH, TN, TX and WV o Facility n MI Relationship: O Spouse O If disabled, indicate reason: roducts: O Medical O Voluntary Life Physiciar MO, NC, OH, TN, TX and WV o Facility n	nly): Date of birth/_// Date of birth/_// Child O Other: Dental O Basic Life Vision n ID: nly):	 		