

Humana Employee Change Form

Please print clearly and fill in each applicable circle.

Current Medical Group number	Benefit number	Class/Division
Current Dental 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 AL, AZ, CA, FL, GA, IL, IN, KS, KY, MO, NC, OH, TN, TX and WV 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 | ☐ Marriage | ☐ Spouse terminates employment |
| ☐ Employer contribution ceases | ☐ Legal separation | ☐ Spouse's employer terminates coverage |
| ☐ Dependent birth / adoption | ☐ Divorce | ☐ Spouse changes from full-time to part-time employment |
| ☐ Dependent change to full-time student | ☐ Spouse deceased | ☐ 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

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 AL, AZ, CA, FL, GA, IL, IN, KS, KY, MO, NC, OH, TN, TX and WV 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 AL, AZ, CA, FL, GA, IL, IN, KS, KY, MO, NC, OH, TN, TX and WV 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 AL, AZ, CA, FL, GA, IL, IN, KS, KY, MO, NC, OH, TN, TX and WV 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 AL, AZ, CA, FL, GA, IL, IN, KS, KY, MO, NC, OH, TN, TX and WV only):
 Primary dentist: _____ Facility number: _____

Signature - please sign below if requesting changes

Employee or legal representative signature: _____ Date: _____

Name and relationship of legal representative: _____