

# 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
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- 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:

- |   |  |   |
|---|--|---|
| <input type="radio"/> Re-hire                               | <input type="radio"/> Marriage         | <input type="radio"/> Spouse terminates employment                          |
| <input type="radio"/> Employer contribution ceases          | <input type="radio"/> Legal separation | <input type="radio"/> Spouse's employer terminates coverage                 |
| <input type="radio"/> Dependent birth / adoption            | <input type="radio"/> Divorce          | <input type="radio"/> Spouse changes from full-time to part-time employment |
| <input type="radio"/> Dependent change to full-time student | <input type="radio"/> Spouse deceased  | <input type="radio"/> 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: \_\_\_\_\_