Humana Employee Cha	inge Form					
Please print clearly and fill in each	applicable circle.					
Current Medical Group number		Benefit numb	er		Cl	ass/Division
Current Dental Group number		Proposed Effe	ective	Date for change	e: / _	/
Company name		Company city	/		Sta	ate
Employee Information and Cl	nanges					
Please provide employee information and	d indicate all applicable	e employee change	es.			
Last name	First name	Ν	11	Social Security	number	
O Change Medical benefit/class to:	Benefit number:			Class/Di	vision:	
O Change or Select Employee P	rimary Care Physicia	n (HMO and POS on	ly):			
Primary care physician:				Physicia	n ID:	
O Change Dental benefit/class to: Benefit number:			Class/Di	vision:		
O Change or Select Employee P	rimary Care Dentist (applicable to AZ, CA	A, FL,	IL, and TX only):		
Primary dentist:				Facility r	number:	
• Change Basic Life benefit/class to:	Benefit number:			Class/Di	vision:	
• Change Basic Life Beneficiary	: Group number:					
Primary beneficiary name: L	•			First name		MI
– Secondary beneficiary name: L	ast name			First name		MI
 Change Voluntary Life Benefic 	ciary: Group number:					
Primary beneficiary name: _	ast name			First name		MI
Secondary beneficiary name:	ast name			First name		MI
O Change Vision benefit/class to: Be	nefit number:			Class/Di	vision:	
• Cancel My Coverage for the following						ort-term Income Protection A O Dependent Care FSA
Qualifying Event Information						
Please indicate the qualifying event date	and reason for employ	yee or dependent o	chang	ges below.		
Qualifying event date: / /						
Reason for change:						
O Re-hire	• Marriage			O Spor	use terminat	es employment
O Employer contribution ceases	old O Legal separat	ion		O Spor	use's employ	/er terminates coverage
O Dependent birth / adoption	O Divorce					from full-time to
• Dependent change to full-time student	• Spouse decea	ased			t-time emplo er:	yment
Change Address Information						
Address change applies to:						
• C Employee only • C Employee and all c	overed dependents					
• Only for the following dependent (plea	ase print full name): La	st name		Firs	st name	MI
New street address			A	Apt / Suite / PO B	ox number	
City	State	Zip c	ode		County	
Email address			P	hone number		

	Group Number Soc	ial Security Number	
Dependent Changes			
Please complete this section a	for all dependent changes.		
1 Last name	First name	MI	Date of birth///
Social Security number	Gender: O Female O Male	Relationship: 🔾 Spouse 🤇	
Dependent status (if applicab	le): O Full-time student O Disabled	If disabled, indicate reason:	
• Add or • Delete depend	dent to/from my current plan for the following p	oroducts: O Medical O Voluntary Life	O Dental O Basic Life
• Change or Select Prima	y Care Physician (HMO and POS only):		O Vision
-	y care i nysician (inito ana i os oniy).	Physician	ı ID.
	(applicable to AZ, CA, FL, IL, and TX only):		
-		Facility n	umber:
		, , , , , , , , , , , , , , , , , , ,	
2 Last name	First name	MI	Date of birth//
Social Security number	Gender: O Female O Male	Relationship: 🔾 Spouse 🤇	O Child O Other:
Dependent status (if applicab	le): O Full-time student O Disabled	If disabled, indicate reason:	
• Add or • Delete depend	dent to/from my current plan for the following p	oroducts: O Medical O Voluntary Life	O Dental O Basic Life
• Change or Select Primar	y Care Physician (HMO and POS only):		
-		Physiciar	n ID:
O Change or Select DHMO	(applicable to AZ, CA, FL, IL, and TX only):		
Primary dentist:		Facility n	umber:
3 Last name	First name	MI	Date of birth//
Social Security number	Gender: O Female O Male	Relationship: O Spouse	O Child O Other:
Social Security number Dependent status (if applicab	Gender:OFemaleOMalele):OFull-time studentODisabled	Relationship: O Spouse C If disabled, indicate reason:	• Child • Other:
Social Security number Dependent status (if applicab	Gender: O Female O Male	Relationship: O Spouse C If disabled, indicate reason: products: O Medical	 Child O Other: Dental O Basic Life
Social Security number Dependent status (if applicab O Add or O Delete dependent	Gender:OFemaleOMalele):OFull-time studentODisabled	Relationship: O Spouse C If disabled, indicate reason:	• Child • Other:
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Social Security number Dependent status (if applicab O Add or O Delete depend O Change or Select Primar Primary care physician: _ O Change or Select DHMO	Gender: O Female O Male le): O Full-time student O Disabled dent to/from my current plan for the following p ry Care Physician (HMO and POS only):	Relationship: O Spouse C If disabled, indicate reason: products: O Medical O Voluntary Life Physiciar	 Child O Other: Dental O Basic Life Vision ID:
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