

# 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 \_\_\_\_\_

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 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: \_\_\_\_\_