Print Form

Group Plan Change Request

HUMANA / HUMANADENTAL

We, us, and our refer to the insuring entities listed on the Business Profile section of the Employer Group Application.

Agent/Producer Information (Please provide your current Agent/Agency of Record information.)

Agent/Agency of Record name: SSN / Tax ID/Humana Agent Number:

Group Information

Company name Proposed Effective Date for change: __ __ / __ __ / __ __ __ __

Street address Apt / Suite / PO Box number

City State Zip code County

Administrative contact Phone number ( )

❍ Attach proposal ❍ Provide quote number (if applicable): _____

To receive confirmation emails when this request is received and completed, indicate email address: _____

Employee Eligibility (Options available as allowed by each state. Contact your Humana sales representative for state eligibility requirements.)

Class of employees: ❍ retirees ❍ hourly ❍ salary ❍ union ❍ non-union ❍ non-management ❍ management ❍ other: _____

How long must employees wait after hire date to become eligible? (if you prefer months, please select "Other" and specify the number of months)

❍ 0 days ❍ 30 days ❍ 60 days ❍ 90 days ❍ Other, specify: _____

New employee effective date provision: ❍ First of month following waiting period ❍ Immediately following waiting period

On all plans, the employee termination date coincides with the effective date provision.

Medical Plan Information (To complete this information, refer to your proposal.)

Group number: _____ Class/Division: _____

Plan name: _____

Network name: _____

Deductible: Participating (In) $ _____ Non-participating (Out) $ ___

Out-of-pocket: Participating (In) $ _____ Non-participating (Out) $ ___

Coinsurance: Participating (In) % _____ Non-participating (Out) %___

Prescription drug/retail card:

- Level 1/2/3/4 $_____ /$_____ /$_____ /_____%
- Group A/B/C/D $____a /$____a /$____a /$____a

Office visit copay: $ _____

Emergency room copay: $_____

Optional riders (list all desired riders): _____

Dental Plan Information (To complete this information, refer to your proposal.)

Group number: _____ Class/Division: _____

Plan name: _____

Orthodontia: DELETE: ❍ Child only ❍ Adult/Child

ADD: ❍ Child only: $ _____ ❍ Adult/Child: $ _____

Open Enrollment: ❍ Delete ❍ Add

Deductible: Participating (In) $ _____ Non-participating (Out) $ ____

Coinsurance: Participating (In) % _____/_____/_____

Non-participating (Out) %_____/_____/_____

Annual maximum: $ _____

Optional riders (list all desired riders): _____

Vision Plan Information (To complete this information, refer to your proposal.)

Group number: _____ Class/Division: _____

Plan name: _____

Open Enrollment: ❍ Delete ❍ Add

Other Changes

Agreement

By signing this Plan Change Request (Request) you are requesting the identified plan change and you fully understand that the Request will have no effect unless and until it is approved in writing by us. We will send written confirmation of the plan change request which may modify your original request. The confirmation will include the effective date of the change, which may be later than the effective date requested. All terms and conditions of the plan not expressly stated in the confirmation remain in effect.

You further understand and agree to comply with all coverage requirements and plan provisions, including underwriting and participation requirements. Payment of premiums on and after the effective date of the change will indicate your agreement to the terms in the confirmation. If you do not wish to accept the changes as described in the confirmation you must provide us written notice of this within 31 days of the date of our confirmation.

Signature - please sign below

Participating Employer or Policyholder Signature: _____

Title: _____ Date: _____

Agent Signature (I am submitting this request at the specific/express direction of the employer): _____ Date: _____

Please photocopy this form and retain for your records.

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