Humana Multilocation Form

HUMANA
Guidance when you need it most

Home Office Information			Group Number
DBA Name of Company			❑ Primary site multi-location ❑ Various site multi-location ❑ Simplified multi-location ❑ Simplified primary site ❑ Simplified various site ❑ Other affiliation
Legal Name of Company			
County	State		
Signature			Date

❑ Bill all group numbers together. (Smaller locations will be simplified, i.e. combined with the main location.)
❑ Bill each group number separately. Additional billing fees may apply.

Instructions

- Various site accounts do not need to complete the rest of the form.
- All other accounts, please complete the information below for each quoted working location. Only complete plan information if different from this employer's main location.
- Group numbers will be completed by sales office staff, if appropriate.

Working location 1

Name of Location, if different:			Group Number
Street Address			County
City	State	Zip	Contact Name:
Medical Plan - If Applicable Plan Name: _____ Network: _____ Deductible In/Out of Network: _____/_____ Coinsurance Limit In/Out of Network: _____/_____ Out of Pocket Amount In/Out of Network: _____/_____ Pharmacy Benefit: _____ Optional Benefits: _____ _____			Phone Number: # Enrolled Employees:* **Dental Plan** **Life Plan**

Working location 2

Name of Location, if different:			Group Number
Street Address			County
City	State	Zip	Contact Name:
Medical Plan - If Applicable Plan Name: _____ Network: _____ Deductible In/Out of Network: _____/_____ Coinsurance Limit In/Out of Network: _____/_____ Out of Pocket Amount In/Out of Network: _____/_____ Pharmacy Benefit: _____ Optional Benefits: _____ _____			Phone Number: # Enrolled Employees:* **Dental Plan** **Life Plan**

Working location 3

Name of Location, if different:			Group Number
Street Address			County
City	State	Zip	Contact Name:
Medical Plan - If Applicable Plan Name: _____ Network: _____ Deductible In/Out of Network: _____/_____ Coinsurance Limit In/Out of Network: _____/_____ Out of Pocket Amount In/Out of Network: _____/_____ Pharmacy Benefit: _____ Optional Benefits: _____ _____			Phone Number: # Enrolled Employees:* **Dental Plan** **Life Plan**

Working location 4

Name of Location, if different:			Group Number
Street Address			County
City	State	Zip	Contact Name:
Medical Plan - If Applicable Plan Name: _____ Network: _____ Deductible In/Out of Network: _____/_____ Coinsurance Limit In/Out of Network: _____/_____ Out of Pocket Amount In/Out of Network: _____/_____ Pharmacy Benefit: _____ Optional Benefits: _____ _____			Phone Number: # Enrolled Employees:* **Dental Plan** **Life Plan**

Working location 5

Name of Location, if different:			Group Number
Street Address			County
City	State	Zip	Contact Name:
Medical Plan - If Applicable Plan Name: _____ Network: _____ Deductible In/Out of Network: _____/_____ Coinsurance Limit In/Out of Network: _____/_____ Out of Pocket Amount In/Out of Network: _____/_____ Pharmacy Benefit: _____ Optional Benefits: _____ _____			Phone Number: # Enrolled Employees:* **Dental Plan** **Life Plan**

* If more than one line of coverage is applied for, count only employees enrolled in the primary coverage. Primary coverage is generally medical, or dental if there is no medical.

Census form

HUMANA®
Guidance when you need it most

Home office (LTD/STD requires salaries)

City:_____ **State:**_____ **ZIP code:**_____

	Age/DOB	Gender	EE, EE+CH, EE+SP, FAM	Other: Salary, COBRA, etc.
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				
21				
22				
23				
24				
25				
26				
27				
28				
29				
30				
31				
32				
33				
34				
35				
36				
37				
38				
39				
40				

Home office (LTD/STD requires salaries)

City:_____ **State:**_____ **ZIP code:**_____

	Age/DOB	Gender	EE, EE+CH, EE+SP, FAM	Other: Salary, COBRA, etc.
41				
42				
43				
44				
45				
46				
47				
48				
49				
50				

Working location #1 (LTD/STD requires salaries)

City:_____ **State:**_____ **ZIP code:**_____

	Age/DOB	Gender	EE, EE+CH, EE+SP, FAM	Other: Salary*, COBRA, etc.
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Working location #2 (LTD/STD requires salaries)

City:_____ **State:**_____ **ZIP code:**_____

	Age/DOB	Gender	EE, EE+CH, EE+SP, FAM	Other: Salary*, COBRA, etc.
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				