

# 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.**