

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? 0 days 30 days 60 days 90 days Other, specify: ___ days

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: _____ Prescription drug/retail card: _____
Plan name: _____ • Level 1/2/3/4 \$ ___ / \$ ___ / \$ ___ / ___ %
Network name: _____ • Group A/B/C/D \$ ___ a / \$ ___ a / \$ ___ a / \$ ___ a
Deductible: Participating (In) \$ _____ Non-participating (Out) \$ _____ Office visit copay: \$ _____
Out-of-pocket: Participating (In) \$ _____ Non-participating (Out) \$ _____ Emergency room copay: \$ _____
Coinsurance: Participating (In) % _____ Non-participating (Out) % _____ Optional riders (list all desired riders): _____

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

Group number: _____ Class/Division: _____ Deductible: Participating (In) \$ _____ Non-participating (Out) \$ _____
Plan name: _____ Coinsurance: Participating (In) % ___ / ___ / ___
Orthodontia: DELETE: Child only Adult/Child Non-participating (Out) % ___ / ___ / ___
ADD: Child only: \$ _____ Adult/Child: \$ _____ Annual maximum: \$ _____
Open Enrollment (100+ groups only): Delete Add Optional riders (list all desired riders): _____

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

Group number: _____ Class/Division: _____ Open Enrollment (100+ groups only): Delete Add
Plan name: _____

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: _____

Please photocopy this form and retain for your records.