Humana Change Form ILLINOIS

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in this application as "Humana." HMO plans offered by Humana Health Plan, Inc. PPO, Classic and Indemnity Medical plans and LIfe and Short Term income protection plans insured or administered by Humana Insurance Company. Dental PPO and Traditional Preferred plans insured or administered by HumanaDental Insurance Company or Humana Insurance Company. Dental Prepaid plans underwritted by The Dental Concern, Ltd.

Please print clearly and fill in each circle where applicable.

Group number | Benefit number | Class/Division

Employee information

Last name | First name | MI

Member ID | Employer name

Change employee address information

New street address | Apt / Suite / PO box number

City | State | Zip code

E-mail address | Phone number

Change or select primary care physician (HMO and POS only)

Employee's primary care physician | Physician ID

Dependent last name | First name | MI

Dependent's primary care physician | Physician ID

Change or select primary care dentist

Group number | Employee's primary care dentist | Dentist ID

Employee's primary care clinic

Dependent last name | First name | MI

Dependent's primary care dentist | Dental Network

Dependent's primary care clinic | Dentist ID

Change plans or dependents

○ Change plan from ______________________________ to ______________________________
If changing to an HMO, POS, PPO, Traditional Preferred or Prepaid plan, please select a primary care physician/dentist and enter on previous page.

○ Change benefit / class to: Benefit number | Class/division

○ Add dependent (complete Dependent Information form and any applicable enrollment forms)

○ Delete dependent (complete Dependent Information form and any applicable enrollment forms)

○ Cancel coverage: Termination date (MMDDYYYY)

Indicate qualifying event:

○ Re-hire
○ Legal separation
○ Employer contribution ceases
○ Spouse changes from full-time to part-time employment
○ Divorce
○ Spouse's employer terminates coverage
○ Spouse deceased
○ Spouse terminates employment
○ Dependent birth / adoption
○ Other: ______________________

Qualifying event date (MMDDYYYY)

Change beneficiary

Basic Life

Primary beneficiary name | Secondary beneficiary name

Voluntary Life

Primary beneficiary name | Secondary beneficiary name

Agreement IL-80124-AA

True and complete acknowledgement

I understand, agree and represent:

- I have read this document or it has been read to me.
- The answers provided within this entire application for coverage are to the best of my knowledge and belief, true and complete.
- Neither my employer nor the agent has the authority to waive a complete answer to any question, determine coverage or insurability, alter any contract, or waive any of Humana's other rights and requirements.
- If this application for coverage is accepted, coverage will be effective on the date specified by Humana on the certificate of coverage/certificate of insurance.
- Any misrepresentation contained herein relied on by Humana may be used to reduce or deny a claim or void the contract within the contestable period if such misrepresentation materially affect the acceptance of the risk.

I hereby enroll for benefits for which I am presently eligible or for which I may become eligible under my employer's group contract(s). If any deductions are required for this coverage, I authorize such deductions from my earnings. I reserve the right to revoke this deduction authorization at any time upon written notice unless I have chosen to use pretax deductions.

This document, together with any supplements, will form part of any contract and be the basis for any certificate of coverage/certificate of insurance issued.

Authorization

My dependents and I authorize any physician, medical practitioner, hospital, clinic, veterans administration facility, other medical or medically-related facility, Pharmacy Benefit Manager, insurance, HMO or reinsuring company, the Medical Information Bureau, Inc., or the Consumer Reporting Agency having information regarding myself and my dependents, including information concerning, advice, diagnosis, treatment and care of physical, psychiatric, mental or emotional conditions, drug, substance or alcohol abuse or illness, and any other non-medical information, to give any and all such information to Humana or their legal representative.

My dependents and I understand and agree:

- The information obtained by use of this authorization may be used by Humana to determine eligibility for coverage, eligibility for benefits under an existing policy and plan administration.
- Any information obtained will not be released by Humana to any person or organization except to reinsuring companies, the Medical Information Bureau, Inc. or other persons or organizations performing health care operations or business or legal services in connection with any application, claim or as may be otherwise lawfully required, or as we may further authorize.
- We may request to receive a copy of this authorization.
- A photographic copy of this authorization shall be as valid as the original.
- This authorization shall be valid for two years from the date shown below.

Employee signature: Date:

Spouse signature: Date:

(If covered dependent)