Group Maintenance Request

Humana.

We, us, our and Humana refer to the insuring entities listed on the Employer Group Application.

AGENT/PRODUCER INFORMATION - Please provide your current Agent/Agency of Record information.

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

GROUP INFORMATION

Company name:	Proposed effective date for change: / /
Provide e-mail address to receive confirmation e-mails when this request is received and completed:	

EMPLOYEE ELIGIBILITY - Options available as allowed by each state. Contact your Humana sales representative for state eligibility requirements.

Probationary waiting period for eligible employees: ◯ 0 days ◯ 30 days ◯ 60 days ◯ 90 days ◉ Other: _____
If you prefer months, please select "Other" and specify the number of months.

Employee effective provision (the employee termination date coincides with the effective date provision):
◯ First of the month following probationary waiting period ◯ Immediately following probationary waiting period

PLAN SELECTION - To complete this information, refer to your proposal. Attach additional signed and dated sheets (reorder AZ-52659), if necessary.

MEDICAL PLAN SELECTION

Group number

◯ Change ◯ Add Plan 1 Quote # _____ / Ref # ___ | ◯ Change ◯ Add Plan 3 Quote # _____ / Ref # ___

◯ Change ◯ Add Plan 2 Quote # _____ / Ref # ___ | ◯ Change ◯ Add Plan 4 Quote # _____ / Ref # ___

DENTAL PLAN SELECTION

Group number

◯ Change ◯ Add Plan 1 Quote # _____ / Ref # ___

◯ Change ◯ Add Plan 2 Quote # _____ / Ref # ___ | ◯ Change ◯ Add Plan 3 Quote # _____ / Ref # ___

Transferring group dental coverage from another group carrier? ◯ Yes ◯ No Include ortho? ◯ Yes ◯ No Term date: / /

Prior Carrier Name:	Number of eligible employees:	Number of COBRA:	Retiree coverage? ◯ Yes ◯ No

VISION PLAN SELECTION

Group number

◯ Change ◯ Add Plan 1 Quote # _____ / Ref # ___ | ◯ Change ◯ Add Plan 2 Quote # _____ / Ref # ___

Number of eligible employees:	Number of COBRA:	Retiree coverage? ◯ Yes ◯ No

LIFE PLAN SELECTION

Group number

◯ Change ◯ Add **Basic Employee Life** Quote # _____ / Ref # ____ Hourly requirements: _____

◯ Change ◯ Add Basic Dependent Life ◯ $20,000/$5,000 ◯ $10,000/$2,500 ◯ $5,000/$1,000

CONTRIBUTION: Employee: Employee/Spouse: Employee/Child: Family:

◯ Change ◯ Add **Voluntary Employee Life** Quote # _____ / Ref # ____ Voluntary Dependent Life? ◯ Yes ◯ No

OTHER CHANGES If there are changes to the group demographic information along with other changes, indicate here.

AGREEMENT AND SIGNATURE

By signing this Group Maintenance 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 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. Coverage is not in effect unless and until you receive written notification from us.

By: _____ _____ _____
Group Authorized Representative (Printed name) (Signature) (Date)

I am submitting this request at the specific/express direction of the employer

Agent signature: _____ Date: _____