

Humana Employee Change Form

Please print clearly and fill in each applicable circle.

Current Group number **633068** Benefit number _____ Class/Division _____
Proposed Effective Date for change: ___ / ___ / _____
Company name **NYCON** Company city _____ State _____

Employee Information and Changes

Please provide employee information and indicate all applicable employee changes.

Last name _____ First name _____ MI _____ Social Security number _____

Cancel My Coverage for the following products: Vision

Qualifying Event Information

Please indicate the qualifying event date and reason for employee or dependent changes below.

Qualifying event date: ___ / ___ / _____

Reason for change:

- | | | |
|---|--|---|
| <input type="radio"/> Re-hire | <input type="radio"/> Marriage | <input type="radio"/> Spouse terminates employment |
| <input type="radio"/> Employer contribution ceases | <input type="radio"/> Legal separation | <input type="radio"/> Spouse's employer terminates coverage |
| <input type="radio"/> Dependent birth / adoption | <input type="radio"/> Divorce | <input type="radio"/> Spouse changes from full-time to part-time employment |
| <input type="radio"/> Dependent change to full-time student | <input type="radio"/> Spouse deceased | <input type="radio"/> Other: _____ |

Change Address Information

Address change applies to:

Employee only Employee and all covered dependents
 Only for the following dependent (please print full name): Last name _____ First name _____ MI _____
New street address _____ Apt / Suite / PO Box number _____
City _____ State _____ Zip code _____ County _____
Email address _____ Phone number _____

Group Number

Social Security Number

Dependent Changes

Please complete this section for all dependent changes.

1 Last name _____ First name _____ MI _____ Date of birth __/__/____

Social Security number _____ Gender: Female Male Relationship: Spouse Child Other: _____

Dependent status (if applicable): Full-time student Disabled If disabled, indicate reason: _____

Add or **Delete** dependent to/from my current plan for the following products: _____ Vision

2 Last name _____ First name _____ MI _____ Date of birth __/__/____

Social Security number _____ Gender: Female Male Relationship: Spouse Child Other: _____

Dependent status (if applicable): Full-time student Disabled If disabled, indicate reason: _____

Add or **Delete** dependent to/from my current plan for the following products: _____ Vision

3 Last name _____ First name _____ MI _____ Date of birth __/__/____

Social Security number _____ Gender: Female Male Relationship: Spouse Child Other: _____

Dependent status (if applicable): Full-time student Disabled If disabled, indicate reason: _____

Add or **Delete** dependent to/from my current plan for the following products: _____ Vision

4 Last name _____ First name _____ MI _____ Date of birth __/__/____

Social Security number _____ Gender: Female Male Relationship: Spouse Child Other: _____

Dependent status (if applicable): Full-time student Disabled If disabled, indicate reason: _____

Add or **Delete** dependent to/from my current plan for the following products: _____ Vision

Signature - please sign below if requesting changes

Employee or legal representative signature: _____ Date: _____

Name and relationship of legal representative: _____