Insured by HUMANA INSURANCE COMPANY
formerly Employers Health Insurance Company

Attention: Billing & Enrollment

REQUEST TO MODIFY THE EMPLOYER GROUP APPLICATION

Employer:____ Group Number:____________________
(exact legal name)

Address:____
(street) (city) (state) (zip)

Company Email Address (if applicable)____

YOU (Participating Employer or Policyholder) request that effective__________ YOUR Employer Group Application will be modified to reflect the change indicated below.

Please complete the following as indicated on the alternate quote: Quote Number____________

Please photocopy this form and attach to YOUR current Employer Group Application and retain for YOUR records.

Medical:

Product Name:____ Deductible: in/out_____________________
(e.g. 90/70 PPO, Traditional 80%)

Out of pocket: in/out__________________________ Network:_____________________________

Coinsurance % & Limit:____________ Office Visit Copay:___________ Drug Copay:__________
(e.g. 90/70 $5000)

Optional Riders:____

Dental:

Product Name:____ Deductible:________________
(e.g. Traditional Preferred 185)

Dental Annual Maximum:___________ Delete Orthodontia ❑ Add Orthodontia ❑ $_________

Other Changes:____

____

By signing this, YOU fully understand that this Request To Modify (Request) will have no effect unless and until it is approved in writing by US (Humana Insurance Company). The effective date of any approved change as a result of this Request will be determined by US and may be later than the effective date requested. The Employer Group Application will be modified only to the extent expressly stated in any correspondence from US which may modify this Request. All other terms of the Employer Group Application will remain in effect. In signing this Request, YOU understand and agree to comply with all coverage requirements and plan provisions including Underwriting and Participation Requirements.

The payment of premiums on and after the effective date of OUR (Humana Insurance Company) written notice approving a change will be deemed to constitute YOUR representation of agreement to the terms of OUR response to the Request and the coverage extended as a result of the Request. If the coverage extended as a result of the Request is unacceptable to YOU and YOU desire to continue coverage under the Policy without the Request being placed in effect, written notice thereof must be given to US within 31 days from the date YOU are notified the change has been approved by US.

Please submit this form to US at least 15 days prior to the requested effective date.

Date:___________ By:____________________________ Title:_____________________________
(signature of Employer)