

# Group Maintenance Request



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: <input type="checkbox"/> 0 days <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days <input type="checkbox"/> 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): <input type="checkbox"/> First of the month following probationary waiting period <input type="checkbox"/> Immediately following probationary waiting period
---

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

### DENTAL PLAN SELECTION Group number

<input type="checkbox"/> Change <input type="checkbox"/> Add Plan 1 Quote # _____ / Ref # ____			
<input type="checkbox"/> Change <input type="checkbox"/> Add Plan 2 Quote # _____ / Ref # ____	<input type="checkbox"/> Change <input type="checkbox"/> Add Plan 3 Quote # _____ / Ref # ____		
Transferring group dental coverage from another group carrier? <input type="checkbox"/> Yes <input type="checkbox"/> No Include ortho? <input type="checkbox"/> Yes <input type="checkbox"/> No Term date: / /			
Prior Carrier Name:	Number of eligible employees:	Number of COBRA:	Retiree coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No

### VISION PLAN SELECTION Group number

<input type="checkbox"/> Change <input type="checkbox"/> Add Plan 1 Quote # _____ / Ref # ____	<input type="checkbox"/> Change <input type="checkbox"/> Add Plan 2 Quote # _____ / Ref # ____	
Number of eligible employees:	Number of COBRA:	Retiree coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No

### LIFE PLAN SELECTION Group number

<input type="checkbox"/> Change <input type="checkbox"/> Add <b>Basic Employee Life</b> Quote # _____ / Ref # ____ Hourly requirements: _____ <input type="checkbox"/> Change <input type="checkbox"/> Add <b>Basic Dependent Life</b> <input type="checkbox"/> \$20,000/\$5,000 <input type="checkbox"/> \$10,000/\$2,500 <input type="checkbox"/> \$5,000/\$1,000			
<b>CONTRIBUTION:</b> Employee: _____ Employee/Spouse: _____ Employee/Child: _____ Family: _____			
<input type="checkbox"/> Change <input type="checkbox"/> Add <b>Voluntary Employee Life</b> Quote # _____ / Ref # ____ Voluntary Dependent Life? <input type="checkbox"/> Yes <input type="checkbox"/> 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: _____