

HumanaOne Plan Change Review Form



Complete the section that applies to the change/review you are requesting.

Policyholder Information (Required for ALL Requests)

Policy Number: _____

Policyholder Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone Number(s): _____

Health Plan Change Request

Please call Billing and Enrollment at 1-800-458-1354 to discuss available benefit options and rates prior to submitting this form for Underwriting review.

Select your new plan below. Please include the deductible amount you would like along with any optional benefits.

MONOGRAM PLAN \$ _____ (single/family) deductible

PORTRAIT PLAN \$ _____ (single/family) deductible

Optional plan benefits: \$0 Prescription Drug Deductible Maternity

AUTOGRAPH PLANS

Share 80 Plus RX \$ _____ (single/family) deductible

Optional plan benefits: \$0 Prescription Drug Deductible Maternity

Share 70 Plus RX \$ _____ (single/family) deductible

AUTOGRAPH PLAN HSA-ELIGIBLE \$ _____ (single/family) deductible

Total (100/70)

Total Plus Rx (100/70)

Share 80 (80/60)

Options available with all health plans

Lifetime Maximum Buy-Up \$ _____

Supplemental Accident Benefit (select level): \$500 or \$1000

(continued)

Exclusion Rider/Rate-Up Review Request

Requests for removal of exclusion riders and rate-ups will be considered if the rider is eligible for review and if the member has been symptom and treatment-free (including prescription drugs) for the previous twelve (12) months.

Member Name _____ Rider/Rate-up Description: _____

Member Name _____ Rider/Rate-up Description: _____

Member Name _____ Rider/Rate-up Description: _____

Member Name _____ Rider/Rate-up Description: _____

Tobacco Status Review Request

Tobacco status will be reviewed if a member has not used tobacco products for the previous (12) months.

Member Name _____

Member Name _____

Any approved policy changes are effective the 1st of the month following Underwriting approval.

You may be contacted for clarification of medical and/or prescription claims submitted for consideration to Humana. You may be required to provide additional medical records or agree to a paramedical examination as part of the review of your request(s.)

Policyholder Signature: X _____ Date: _____

Spouse Signature: X _____ Date: _____
(If covered dependent)

Please fax or mail the completed form to HumanaOne Underwriting:

Fax: 608-237-0143
Mail: Humana Inc.
Attention: Underwriting (Post Issue)
N19 W24133 Riverwood Dr Ste 250
Waukesha WI 53188

If you have any questions regarding this form, please call HumanaOne at 1-800-825-7858.