



## 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: \_\_\_\_\_

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**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 \_\_\_\_\_

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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.