HUMANA®
www.humana.com
Toll Free: 800-232-2006
1100 Employers Blvd.
Green Bay, WI 54344

GROUP COVERAGE REINSTATEMENT/TERMINATION REQUEST FORM

Company Number: _____
Company Name: _____

CHOOSE THE OPTION THAT DESCRIBES YOUR INTENT WITH REGARD TO YOUR INSURANCE COVERAGE WITH HUMANA

_____ I request consideration for reinstatement of this terminated coverage. I understand payment of premium does not guarantee reinstatement and all coverage remains terminated while you review my request. If reinstatement is approved, all coverage will be continued without a lapse in coverage. I also agree to pay all future premiums by the due date indicated on the monthly billing statement. I understand that if my coverage is reinstated by this request, Humana reserves the right to deny future reinstatement requests.

_____ I request that the insurance coverage provided under the above group be terminated on _____. I have changed to the following insurance carrier:

Name _____,
Group Number _____,
Phone Number _____.

I understand that Humana will not be liable for any claims incurred after the requested termination date.

_____ I request that the insurance coverage provided under that above group be terminated on _____. The requested term date cannot be prior to _____, which is the paid through date for the coverage. I understand that Humana will not be liable for any claims incurred after the requested termination date.

THIS REQUEST MUST BE SIGNED AND DATED TO BE VALID FOR CONSIDERATION.

_____ _____
Authorized Signature **Date**

_____
Title