HUMANA INSURANCE COMPANY MAIL TO:

BAY BRIDGE ADMINISTRATORS, LLC

P.O. BOX 161690
AUSTIN, TEXAS 78716

POLICYHOLDER'S CHANGE AND SERVICE REQUEST

Policy Number (use 1 form per policy)/ Social Security No.	Name of Insured (Last, First, Middle)	Agent Name and Number (Please Print)

Take the following action(s) regarding this policy subject to Humana Insurance Company

☐ **Policy Changes, Reduction or Removals**
 ☐ Change from *Family to Individual* coverage on health policy due to _____
 If due to death of Named Insured, Name of Spouse_____
 Social Security No._____ Date of Birth_____
 ☐ Add Newborn Child _____
 Name of Newborn_____ Date of Birth of Newborn_____
 ☐ If Divorced- Date of Divorce Decree_____

☐ **Change Name of**
 ☐ Named Insured From_____
To_____
 Reason for Change_____ (complete Change of Address Form if needed)
 Note: If the reason for the change is other than marriage, a certified copy of the court order is required.

☐ **Address Change**

_____
Name (last, First, Middle)

_____
Street   City, State, Zip

☐ **Payroll Allotment Billing Changes**
 Case No._____ Social Security No._____
 Named Insured Name_____

Place Policy on Direct Bill Effective: _____
 ☐ ANNUAL ☐ SEMI-ANNUAL ☐ QUARTERLY ☐ BANK DRAFT*
* *One Month's Premium, Bank Draft Authorization and Voided Check Required*

☐ **Application for Duplicate Policy**
 ☐ I certify that the above policy has been lost or destroyed and that said policy is not assigned or pledged in any way whatsoever. I, therefore, request the issuance of a duplicate of said policy and agree that should the original policy be found or in any way come into my possession, I will return or cause the same to be returned to Humana Insurance Company., its successors or assigns. It is distinctly understood and agreed that the original policy shall become null and void immediately upon issuance of the duplicate policy herein requested.

☐ **Other Instructions (Be specific)**

X _____   _____
 Signature of Named Insured   **Date**

B-5000