Humana Multilocation Form

HUMANA
Guidance when you need it most

Home Office Information			Group Number
DBA Name of Company			❑ Primary site multi-location ❑ Various site multi-location ❑ Simplified multi-location ❑ Simplified primary site ❑ Simplified various site ❑ Other affiliation
Legal Name of Company			
County	State		
Signature			Date

❑ Bill all group numbers together. (Smaller locations will be simplified, i.e. combined with the main location.)
❑ Bill each group number separately. Additional billing fees may apply.

Instructions

- Various site accounts do not need to complete the rest of the form.
- All other accounts, please complete the information below for each quoted working location. Only complete plan information if different from this employer's main location.
- Group numbers will be completed by sales office staff, if appropriate.

Working location 1

Name of Location, if different:			Group Number
Street Address			County
City	State	Zip	Contact Name:
Medical Plan - If Applicable Plan Name: _____ Network: _____ Deductible In/Out of Network: _____/_____ Coinsurance Limit In/Out of Network: _____/_____ Out of Pocket Amount In/Out of Network: _____/_____ Pharmacy Benefit: _____ Optional Benefits: _____ _____			Phone Number: # Enrolled Employees:* **Dental Plan** **Life Plan**

Working location 2

Name of Location, if different:			Group Number
Street Address			County
City	State	Zip	Contact Name:
Medical Plan - If Applicable Plan Name: _____ Network: _____ Deductible In/Out of Network: _____/_____ Coinsurance Limit In/Out of Network: _____/_____ Out of Pocket Amount In/Out of Network: _____/_____ Pharmacy Benefit: _____ Optional Benefits: _____ _____			Phone Number: # Enrolled Employees:* **Dental Plan** **Life Plan**

Working location 3

Name of Location, if different:			Group Number
Street Address			County
City	State	Zip	Contact Name:
Medical Plan - If Applicable Plan Name: _____ Network: _____ Deductible In/Out of Network: _____/_____ Coinsurance Limit In/Out of Network: _____/_____ Out of Pocket Amount In/Out of Network: _____/_____ Pharmacy Benefit: _____ Optional Benefits: _____ _____			Phone Number: # Enrolled Employees:* **Dental Plan** **Life Plan**

Working location 4

Name of Location, if different:			Group Number
Street Address			County
City	State	Zip	Contact Name:
Medical Plan - If Applicable Plan Name: _____ Network: _____ Deductible In/Out of Network: _____/_____ Coinsurance Limit In/Out of Network: _____/_____ Out of Pocket Amount In/Out of Network: _____/_____ Pharmacy Benefit: _____ Optional Benefits: _____ _____			Phone Number: # Enrolled Employees:* **Dental Plan** **Life Plan**

Working location 5

Name of Location, if different:			Group Number
Street Address			County
City	State	Zip	Contact Name:
Medical Plan - If Applicable Plan Name: _____ Network: _____ Deductible In/Out of Network: _____/_____ Coinsurance Limit In/Out of Network: _____/_____ Out of Pocket Amount In/Out of Network: _____/_____ Pharmacy Benefit: _____ Optional Benefits: _____ _____			Phone Number: # Enrolled Employees:* **Dental Plan** **Life Plan**

* If more than one line of coverage is applied for, count only employees enrolled in the primary coverage. Primary coverage is generally medical, or dental if there is no medical.