# Policy Service Request *(Policy Required if indicated)*

Humana®

Kanawha Insurance Company, PO Box 14330, Lexington, KY 40512

Fax: 1-800-734-9516

Insured's Name _____ Policy Number _____

Owner's Name _____ Owner's Social Security Number _____

Owner's Address _____

City _____ State _____ ZIP+4_____

Owner's Telephone _____

## ☐Section A — Payor Address Change

Address _____

City _____ State _____ ZIP+4_____

## ☐Section B — Legal Name Change *(Does not change designation)*

☐ Beneficiary _____

Relationship _____ Date of Birth _____/_____/_____

☐ Insured _____

☐ Contingent Beneficiary _____

☐ Applicant _____ Payor _____

☐ Owner _____

## ☐Section C — Premium Changes *(Requires Home Office approval)*

Change Premium Payment: ☐ Annual ☐ Semi-annual ☐ Quarterly ☐ Monthly | ☐ Direct Bill ☐ Bank Draft *(Bank Authorization & voided check required)*

Contact Home Office for Special Request and Minimum Requirements.

## ☐ Section D — Convert Insurance To:

Product/Plan _____ Modal Premium _____

Insurance Amount _____ Effective _____/_____/_____

Tobacco User: ☐ Yes ☐ No Have you used tobacco products in the last 12 months? ☐ Yes ☐ No

A urine specimen is required if original was not a NTU Plan.

☐Continue Remaining Insurance, or ☐Cancel Remaining Insurance

| | **Continue** | **Terminate** |
|---|---|---|
| ☐ Children's Rider | ☐ | ☐ |
| ☐ Waiver of Premium | ☐ | ☐ |
| ☐ AD&D Rider | ☐ | ☐ |

Dividend Option: *(Complete Form 6106 Section A for Paid-up Additions)*

☐Paid in Cash ☐Left to Accumulate

## ☐ Section E — Policy Value Options *(Premium must be current)*

I request that my policy be placed on: ☐Reduced Paid-Up Insurance ☐Extended Term Insurance

Discontinue Premium Payments Effective _____/_____/_____

*(If requesting premium reduction via dividend, complete Form 6096)*

## ☐ Section F — Plan Change, Reduction and/or Removal

Coverage Change Effective _____/_____/_____

☐Change product/plan of insurance: From _____ To _____

☐Reduce amount of insurance to: _____

☐Remove Dependent, Benefit or Rider _____

*(Complete Form 6106 if changing plan from Tobacco User to Non-Tobacco User.)*

☐ Change Date of Birth to _____/_____/_____ Name of Insured that Change Applies to_____

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If the Policy requires that the above change(s) be endorsed in the Policy, it is requested that the Policy be modified to permit the change(s) without endorsement of the Policy.

Signature _____ _____/_____/_____

Policyowner Date



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- Free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.
- Free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as translated documents or oral interpretation.

If you need these services, call 1-855-448-6982 or if you use a TTY, call 711.

If you believe that Humana Inc. and its subsidiaries have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Discrimination Grievances
P.O. Box 14618
Lexington, KY 40512-4618

If you need help filing a grievance, call 1-855-448-6982 or if you use a TTY, call 711.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800–368–1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html