Please complete all four sections. Submit this form and any supporting documentation to MSOPSupport@humana.com for review.

**Section 1: Agent Information** (All fields required)

|  |  |  |  |
| --- | --- | --- | --- |
| Agent Name: |  | Agent SAN: |  |
| Agent E-Mail Address: |  |

**Section 2: Member Information** (As written on application, to assist in locating account. All fields required.)

|  |  |  |  |
| --- | --- | --- | --- |
| Member Name: |  | Member DOB: |  |
| Member Medicare ID: |  | Contract/PBP *or* Group/BSN *or* Plan Name/Effective Date written on application: |  |

**Section 3: Select the item(s) for correction by placing an “X” in the appropriate box(es). Complete all applicable fields.**

|  |  |  |
| --- | --- | --- |
| [ ] Medicare ID |  | [ ] Contract - PBP (i.e. S5884-001) |
| Medicare ID on application: |  |  | Contract/PBP on application: |  |
| Correct Medicare ID: |  |  | Correct Contract/PBP: |  |
|  |  |
| [ x ] Effective Date |  | [ x ] Election Type Code / SEP |
| Effective Date on application: |  |  | ETC / SEP on application: |  |
| Correct effective date: |  |  | Correct ETC / SEP: |  |
|  |
| [ ] Other / Not Listed Above  |
| Fully describe correction needed, including A) how the information appeared on the application and B) what that incorrect information should be changed to. Be as detailed as possible. |
|  |

**Section 4: Please provide background information regarding why the correction is needed.** (Required field)

|  |
| --- |
|  |

Instructions for Completing the Agent Statement of Enrollment Corrections

**Section 1: Agent Information**

The following fields are required:

* Agent Name
* Agent SAN
* Agent E-Mail Address:

**Section 2: Member Information**

The following fields are required:

* Member Name
* Member DOB
* Member Med ID (as submitted) Note: Please provide the Medicare ID that was on member’s application in this field
* Contract/PBP provided on application

**Section 3: Items for Correction**

Type an “X” in the bracket next to the item or items that need to be corrected (options are Medicare ID, Contract/PBP, Effective Date, Election Type Code/SEP, and Other/Not Listed Above).

If the bracket has been marked with an X, ALL fields in that section of the form must be completed.

Example: If the bracket next to Election Type Code has been marked with an X, ETC on application and Correct ETC fields are required.

**Section 4: Background Information**

This is a required field.

Please provide the background information describing how the error occurred.