



# HUMANA DENTAL

## Enrollment/Change Form

GROUP # <b>628611</b>	DIVISION #	EFFECTIVE DATE
-----Human Resources Use Only-----		

### Section 1 \* ALL EMPLOYEES COMPLETE SECTION 1

<b>Employee Start Date</b>	<b>Job Title</b>	<b>Social Security #</b>	<b>Email Address</b>
<b>Last Name</b>		<b>First</b>	<b>M.I.</b>
<b>Address</b>		<b>City</b>	<b>State</b> <b>Zip</b>
<b>Date of Birth</b>	<b>Sex (M/F)</b>	<b>Marital Status</b>	<b>Home Phone #</b> <b>Work Phone #</b>
<b>Type of Coverage</b>			
<input type="checkbox"/> Employee only <input type="checkbox"/> Family (Employee plus dependent(s))			
<b>Employee Status</b>		<b>Union</b>	
<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time		<input type="checkbox"/> Non-Represented <input type="checkbox"/> Local 212 Teacher <input type="checkbox"/> Local 212 Para-Professional <input type="checkbox"/> Local 587 <input type="checkbox"/> Local 715	

### Section 2 \*\* NEW ENROLLEES COMPLETE SECTIONS 2 & 3

ELIGIBLE DEPENDENTS			
Last Name (If diff. from employee), First Name, MI	Sex (M/F)	Soc. Sec #	Birth Date
Spouse			
Domestic Partner*			
Child			
Child			
Child			
Child			

\*Same sex partner only; does not apply to Local 587. Must attach supporting documentation (see HR for appropriate forms).

### Section 3

Do you or any eligible dependent have other dental coverage as of the effective date of enrollment?    Yes    No  
 (Answer this question based on effective date of enrollment or change.)

If yes to the above question, complete the following:

Person's name \_\_\_\_\_

Employer Name \_\_\_\_\_ Carrier Name \_\_\_\_\_ Plan Number \_\_\_\_\_

Person's name \_\_\_\_\_

Employer Name \_\_\_\_\_ Carrier Name \_\_\_\_\_ Plan Number \_\_\_\_\_

**SEE REVERSE**

# Change Form

**Section 4 - Complete this section if currently enrolled in Humana dental plan and are reporting changes only.**

Effective date of change: _____				<b>Please specify change and update in appropriate section.</b>					
<input type="checkbox"/> Employee name change		<input type="checkbox"/> Employee address change		<input type="checkbox"/> Termination		<input type="checkbox"/> Adoption			
<input type="checkbox"/> Birth (Copy of birth certificate required)		<input type="checkbox"/> Date of marriage (Copy of marriage certificate required)		_____					
<input type="checkbox"/> Date of divorce _____		<input type="checkbox"/> Other _____		_____					
<input type="checkbox"/> Add dependents		<input type="checkbox"/> Remove dependents		Reason: _____					
Spouse				SS#		Birth Date		Sex	
Domestic Partner*				SS#		Birth Date		Sex	
Dependent				SS#		Birth Date		Sex	
Dependent				SS#		Birth Date		Sex	
*Same sex partner only; does not apply to Local 587. Must attach supporting documentation (see HR for appropriate forms).									

**Signature and date are required.**

I hereby certify that all of the above information is true and correct. I understand that coverage will not be effective until all questions regarding eligibility for coverage have been satisfactorily resolved. I understand that I may not change the coverage elections that I make on the Employee Enrollment/Change Form until the plan's next open/annual enrollment period or unless otherwise permitted by the Plan. Please refer to your Summary Plan Description for specific details of your benefit plan.

I hereby apply for coverage and authorize deductions from my earnings for the amount required, if any, to cover any contribution for coverage.

\_\_\_\_\_

EMPLOYEE SIGNATURE DATE

*MATC is an Affirmative Action/Equal Opportunity institution and complies with all requirements of the Americans with Disabilities Act.*

Human Resources Use Only			
COSMO _____	Billing _____	(PT Only)	
Humana _____	SPD _____		