



HUMANA PREMIER HMO

Enrollment/Change Form

GROUP # 222869	BEN SEQ #	CLASS	PLAN #	OPTION #	EFFECTIVE DATE
-----Human Resources Use Only-----					

Section 1 * ALL EMPLOYEES COMPLETE SECTION 1

Employee Start Date	Job Title	Social Security #	Email Address		
Last Name		First	M.I.		
Address		City	State	Zip	
Date of Birth	Sex (M/F)	Marital Status	Home Phone #	Work Phone #	
Type of Coverage <input type="checkbox"/> Employee only <input type="checkbox"/> Family (Employee plus dependent(s))			Employee's Physician (Required)		
Employee Status <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time		Union <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.

YOUR ELIGIBLE DEPENDENTS						
Last Name (If diff. from employee), First Name, MI	Sex (M/F)	Social Security #	Birth Date	Physician (Required)	Do you provide >50% support?	Is depend disabled ?
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 - Complete this section if new to Humana coverage.

Do you or any eligible dependent have other health coverage as of the effective date of enrollment? Yes, single Yes, family No

If yes to the above question, complete the following:

Person's name _____

Employer Name _____ Carrier Name _____ Plan Number _____

Are you or any of your dependents eligible for Medicare benefits? No Yes

If yes, Name _____, and Medicare Member # _____.

Name _____, and Medicare Member # _____.

Name _____, and Medicare Member # _____.

SEE REVERSE

Change Form

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

Effective date of change: _____ Please specify change and update in appropriate section.				
<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: _____		
<hr/>				
Spouse	SS#	Birth Date	Sex	Physician (Required)
<hr/>				
Domestic Partner*	SS#	Birth Date	Sex	Physician (Required)
<hr/>				
Dependent	SS#	Birth Date	Sex	Physician (Required)
<hr/>				
Dependent	SS#	Birth Date	Sex	Physician (Required)
*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 Employee Benefit Booklet 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 _____		