HUMANA DENTAL

Enrollment/Change Form

GROUP #	DIVISION #	EFFECTIVE DATE
628611		

---------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
- ☐ Employee only
- ☐ Family (Employee plus dependent(s))

Employee Status
☐ Full-time ☐ Part-time

Union
☐ Non-Represented ☐ Local 212 Teacher ☐ Local 212 Para-Professional ☐ Local 587 ☐ 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: ________________ **Please specify change and update in appropriate section.**

☐ Employee name change ☐ Employee address change ☐ Termination ☐ Adoption

☐ Birth (Copy of birth certificate required) ☐ Date of marriage (Copy of marriage certificate required) ____________________

☐ Date of divorce____________________ ☐ Other ____

☐ Add dependents ☐ 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 ___________		