



**Group Name: City of Miami Springs**

## Benefits Enrollment Form

**Please print and complete the following information:**

Social Security No.	Last Name	First	MI	Date of Birth
Home Address		City	State	ZIP Code
Home Phone	Business Phone	Email Address		
Effective Date	Sex M <input type="checkbox"/> F <input type="checkbox"/>	Facility Number (DHMO Only)	Number of Dependents	

**List All Your Eligible Dependents That Are To Be Covered**

First	MI	Last	Facility Number (DHMO Only)	Sex	Birth Date
Spouse:				M <input type="checkbox"/> F <input type="checkbox"/>	/ /
Child:				M <input type="checkbox"/> F <input type="checkbox"/>	/ /
Child:				M <input type="checkbox"/> F <input type="checkbox"/>	/ /
Child:				M <input type="checkbox"/> F <input type="checkbox"/>	/ /
Child:				M <input type="checkbox"/> F <input type="checkbox"/>	/ /
Child:				M <input type="checkbox"/> F <input type="checkbox"/>	/ /
Child:				M <input type="checkbox"/> F <input type="checkbox"/>	/ /

<b>PLEASE CHECK YOUR CHOICE</b>	<b>Group Number VS3160</b>
	<b>Vision Plan VCP151</b>
<b>Employee Only</b>	<input type="checkbox"/>
<b>Employee + Family</b>	<input type="checkbox"/>

I wish to enroll in the plan indicated above as offered through my employer. I understand that this is a minimum one (1) year contract. I hereby authorize my employer to deduct all applicable contribution amounts from my salary or other compensation for the plan year, and for future renewal period(s). I understand that such contribution rate is subject to change on the anniversary date of the plan.

I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.

Signature: X \_\_\_\_\_ Date: \_\_\_\_\_