



**CITY OF MIAMI SPRINGS
HUMANA MEDICAL INSURANCE ENROLLMENT FORM**

HR DEPT USE: Coverage Effective Date _____

Please print and complete the following information:

Last Name		First Name		M.I.	Social Security No.	
Home Street Address			City		State	ZIP Code
Cell Phone Number		Home Phone Number		Work Phone Number		
Date of Birth	Sex M <input type="checkbox"/> F <input type="checkbox"/>		Personal Email Address			

CHECK ONE: **New Hire** **Open Enrollment Change** **Qualifying Event Change (attach documentation of qualifying event)**

Choose your plan:

<input type="checkbox"/> HMO Bronze Plan	<input type="checkbox"/> HMO Silver Plan	<input type="checkbox"/> HMO Gold Plan/Police HMO	<input type="checkbox"/> POS Plan	<input type="checkbox"/> Decline Coverage
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Choose your coverage:

<input type="checkbox"/> Employee	<input type="checkbox"/> Employee + Spouse	<input type="checkbox"/> Employee + Child(ren)	<input type="checkbox"/> Employee + Family
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If choosing Employee + Spouse, Employee + Children, or Employee + Family coverage, please list all eligible dependents who will be covered:

Last Name	First Name	MI	Social Security Number	Sex	Date of Birth	Action Requested
Spouse:				M <input type="checkbox"/> F <input type="checkbox"/>	/ /	<input type="checkbox"/> ADD <input type="checkbox"/> DELETE
Child 1:				M <input type="checkbox"/> F <input type="checkbox"/>	/ /	<input type="checkbox"/> ADD <input type="checkbox"/> DELETE
Child 2:				M <input type="checkbox"/> F <input type="checkbox"/>	/ /	<input type="checkbox"/> ADD <input type="checkbox"/> DELETE
Child 3:				M <input type="checkbox"/> F <input type="checkbox"/>	/ /	<input type="checkbox"/> ADD <input type="checkbox"/> DELETE
Child 4:				M <input type="checkbox"/> F <input type="checkbox"/>	/ /	<input type="checkbox"/> ADD <input type="checkbox"/> DELETE

I wish to enroll in the plan indicated above as offered through my employer. I understand that this is a 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	Date
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