HUMANA.
CompBenefits

HR DEPARTMENT USE:
Coverage Effective Date _____

HUMANA VISION INSURANCE ENROLLMENT FORM

Group Name:	Group No.:	Vision Plan:
CITY OF MIAMI SPRINGS	**VS3160**	**VCP151**

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	Personal Email Address
	M ☐ F ☐	

Choose your plan:

☐ Employee Only	☐ Employee + Family	☐ Decline Coverage

If choosing the Employee + Family plan, please list all eligible dependents who will be covered:

Last Name / First Name / MI	Sex	Date of Birth
Spouse:	M ☐ F ☐	/ /
Child 1:	M ☐ F ☐	/ /
Child 2:	M ☐ F ☐	/ /
Child 3:	M ☐ F ☐	/ /
Child 4:	M ☐ F ☐	/ /
Child 5:	M ☐ F ☐	/ /

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 _____