Humana.

HR DEPT USE: Coverage Effective Date _____

CITY OF MIAMI SPRINGS
HUMANA MEDICAL INSURANCE ENROLLMENT FORM

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 ☐	

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

Choose your plan:

☐ HMO Silver Plan	☐ HMO Gold Plan/Police HMO	☐ POS Plan	☐ Decline Coverage

Choose your coverage:

☐ Employee	☐ Employee + Spouse	☐ Employee + Child(ren)	☐ Employee + Family

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 ☐ F ☐	/ /	☐ ADD ☐ DELETE
Child 1:		M ☐ F ☐	/ /	☐ ADD ☐ DELETE
Child 2:		M ☐ F ☐	/ /	☐ ADD ☐ DELETE
Child 3:		M ☐ F ☐	/ /	☐ ADD ☐ DELETE
Child 4:		M ☐ F ☐	/ /	☐ ADD ☐ 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

Rev. 9/15/2021