HUMANA®

Specialty Benefits

Benefits Enrollment Form

Group Name: Hampshire County BOE

Please complete the following information:				
Social Security No.	Last Name	First	Middle	Date of Birth
Home Address		Home Phone		Gender
City	State / ZIP Code	Business Phone		Facility Number

List All Your Eligible Dependents That Are To Be Covered			
First MI Last	Facility Number	Sex	Birth Date
Spouse:		M☐ F☐	/ /
Child:		M☐ F☐	/ /
Child:		M☐ F☐	/ /
Child:		M☐ F☐	/ /
Child:		M☐ F☐	/ /
Child:		M☐ F☐	/ /
Child:		M☐ F☐	/ /

Effective Date:	Group Number **See Below**	Your E-mail Address	Agent Number **0304075KY**

PLEASE CHECK YOUR CHOICE	☐ Dental Plan 862335	☐ Vision Plan 862335
Bi-Monthly Rates (24 pay)	**7/1/18 – 6/30/19**	**7/1/18 – 6/30/19**
Employee Only	☐ EMPER PAID	☐ EMPER PAID
Employee + One	☐ $ 13.93	☐ $ 3.42
Employee + Family	☐ $ 35.92	☐ $ 5.74

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: _____ **Date:** _____