Employee Enrollment / Change Form

Administered by:
Humana Dental Insurance Co.
1100 Employers Boulevard
Green Bay, WI 54344

☐ **ADD Dependent under age 26 law**

☐ **COBRA** ☐ **New Employee** ☐ **Change** ☐ **Retiree Plan (eligible up to age 65)**

Employer Name **City of Green Bay**	**Group Number**		**Employee Job Location**
Employee Start Date	**Class**		**Job Title**
Date Notified HumanaDental			**Date Payroll/Payment Changes Completed**
Social Security Number	**EE Last Name**		**First Name**
Address	**City**	**State**	**Zip** **Email Address**
Date of Birth	**Sex**	**Marital Status**	**Home Telephone Number** **( )**

Do you or any family member currently have other Dental Coverage? ☐ **Yes, Single** ☐ **Yes, Family** ☐ **No**

If yes to the above question, complete the following: Person's Name_____
Employer Name_____ **Carrier Name**_____ **Plan Number**_____

Dental Plan
☐ **Employee Only** ☐ **Family** ☐ **Waive****
☐ **12 month waiting period applies**

**** If waiving coverage, or an employee with dependents electing only employee coverage, read NOTICE TO LATE ENROLLEES on the reverse side.**

**** If you and your eligible dependents are waiving ALL coverages offered under this plan, please sign and date below.**

I proclaim that I was not pressured or forced by the employer named above, or the writing agent or Humana into waiving the above noted coverage. I freely and voluntarily waive the above noted coverage.

_____ _____
EMPLOYEE SIGNATURE **DATE**

IF YOU ARE ELECTING OR CHANGING ANY OF THE ABOVE COVERAGES, PLEASE COMPLETE THE REMAINING SECTIONS OF THIS FORM ON THE REVERSE SIDE.

COMPLETE THIS SECTION IF ELECTING DEPENDENT COVERAGE

NAME	Last	First	SS#	Birth Date	Sex				DOES CHILD RESIDE WITH YOU?	DO YOU PROVIDE 50% + SUPPORT	**CREDITS THIS SEMESTER
Spouse											
	Last	First	SS#	Birth Date	Sex	Natural Child	Step Child	Other *			
Child 1						☐	☐	☐			
2						☐	☐	☐			
3						☐	☐	☐			
4						☐	☐	☐			
5						☐	☐	☐			

* If "OTHER", Please explain _____

** What semester is student registered for? _____

COMPLETE THIS SECTION IF MAKING CHANGES

Effective date of change: _____ Please specify change and update in appropriate section.

☐ Employee name change ☐ Employee address change ☐ Job location change ☐ Job title change
☐ Return to work ☐ Other coverage change ☐ Date of marriage _____
☐ Other _____ ☐ Date of divorce _____
☐ Add dependents ☐ Remove dependents (list names) _____ Reason: _____
☐ Add Dependent under age 26 law
☐ Add coverage ☐ Voluntarily Terminate Coverage (Indicate which coverages) _____
☐ State/Federal Continuation

☐ Employment termination: Reason: _____ Last Day Worked _____ Date Coverage Terminated _____

I hereby authorize any person, including physicians, hospitals, insurance companies and service organizations, to release to HumanaDental Insurance Company any medical information regarding me or my dependents for any purpose, including application for insurance, claim adjudication, medical record audit and peer review activities. This authorization shall be valid for the duration of my coverage under this plan.

I hereby certify that all of the above information is true and correct. I understand that coverage will not be effective until all questions regarding eligibility for coverage have been satisfactorily resolved by HumanaDental Insurance Company.

I hereby apply for coverage and authorize deductions from my earnings for the amount required, if any, to cover any contribution for coverage.

_____ _____

EMPLOYEE SIGNATURE **DATE**

NOTICE TO LATE ENROLEES

If you are not covered within 30 days after becoming eligible for dental coverage, you may be required to fulfill the following requirements prior to receiving coverage:

Employees who fail to enroll within 30 days when coverage is first available to them, or who fail to secure family coverage within 31 days after the date of marriage, or who fail to add a newborn or adopted child within 30 days of the child's date of birth, adoption or placement for adoption, will be considered a late enrollee.

If you are a late enrollee, you will pay the full amount of premium for the first 12 months coverage is in force. During that time, benefits shall be limited to preventive services and services due to accidental bodily injury.