HUMANA
Specialty Benefits

Benefits Enrollment Form

Group Name: Anderson 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		

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: (Agent to fill in)	Group Number (Agent to fill in)	Your E-mail Address	Agent Number 1024303 / 1284915

PLEASE CHECK YOUR CHOICE	☐ Dental Plan 1 Year Rate	☐ Vision Plan 2 Year Rate
Monthly Rates	**11/1/11-10/31/2012**	**11/1/11-10/31/2012**
Employee Only	☐ $22.85	☐ $7.28
Employee + One	☐ $51.96	☐ $14.57
Employee + Family	☐ $77.28	☐ $19.52

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: X _____ Date: _____