CITY OF TAMPA RETIREE Group #773466 Div. 03
Dental Enrollment/Change/Termination Form

☐ **Enrollment** ☐ **Change** ☐ **Termination** **Effective Date:_____**
Reason for change _____

GENERAL INFORMATION

Employee Name: _____ Social Security #: _____
Address:_____ City: _____ State:_____ Zip:_____
Phone:_____ Email address:_____ Date of Hire:_____

EMPLOYEE AND DEPENDENT INFORMATION

	Name	Date of Birth	Facility #**	Gender	Action
Employee:	_____	_____	_____	☐ M ☐ F	☐ Add ☐ Cancel
Spouse:	_____ SS#_____	_____	_____	☐ M ☐ F	☐ Add ☐ Cancel
Child:	_____SS#_____	_____	_____	☐ M ☐ F	☐ Add ☐ Cancel
Child:	_____SS#_____	_____	_____	☐ M ☐ F	☐ Add ☐ Cancel
Child:	_____SS#_____	_____	_____	☐ M ☐ F	☐ Add ☐ Cancel

**Facility Number is only required if DHMO HS195 plan is chosen

EMPLOYEE SIGNATURE AND DATE

Please Note:
Any person who, with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. I hereby consent, personally and on behalf of any family members enrolled, to the unrestricted release of my/our dental records maintained by participating physicians to Humana for, but not limited to, claims verification and quality assessment review, and to any other participating physician who may be or become involved in my/our dental care.

Employee Signature_____ Date:_____

Please mail this completed form to:

Humana Commercial Enrollment
PO Box 14330
Lexington, KY 40512

Please select your plan:			
DHMO HS195 Plan			
Retiree	☐		$13.22
Retiree + One	☐		$26.18
Retiree + Family	☐		$46.54
PPO Plan			
Retiree	☐		$33.78
Retiree + One	☐		$64.17
Retiree + Family	☐		$105.82