To Select Coverage, Follow These Steps

1. Complete the Enrollment Form.

2. Participating Dental Provider #_____

3. Choose Payment Method: - Include a check for the first payment.
   - ☐ Bi-Weekly (Direct Deposit through your payroll office)
   - ☐ Monthly Check Service (complete and include form)
   - ☐ Quarterly Billing

Humana Enrollment Form

	Last Name First Name MI	Sex: ☐ Male ☐ Female
Social Security #:	(Home) Street:	Date of Birth:
Date of Employment:	(Home) City State Zip	Home Phone:
Federal Department & Agency:	Personnel Office Phone #	Work Phone:

IF DEPENDENT COVERAGE IS ELECTED, YOU MUST ENROLL ALL ELIGIBLE DEPENDENTS

First Name M.I. Last Name (If different)	Sex	Date of Birth
SPOUSE:		
CHILD(REN):		

* If the address of any child is different from the member, please show child's address with name above.

* If requesting coverage for a dependent child other than a son or daughter, please forward legal custody papers.

To the best of my knowledge and belief, each of the statements and answers supplied in this form is complete and true, and constitute the sole basis for, and are the inducement for, the issuance of any insurance.

Date:_____ Member's Signature:_____

MAIL COMPLETED FORM(S) TO:
Mass Benefits Consultants, Inc. □ P.O. Box 828 □ Annandale, VA 22003-0828
Or email to: mbc@massbenefits.com
Or fax to: (703) 642-3834