

**CITY OF TAMPA RETIREE Group #773466 Div. 03
Dental Enrollment/Change/Termination Form - 2021**



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: _____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Add <input type="checkbox"/> Cancel
Spouse: _____ SS# _____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Add <input type="checkbox"/> Cancel
Child: _____ SS# _____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Add <input type="checkbox"/> Cancel
Child: _____ SS# _____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Add <input type="checkbox"/> Cancel
Child: _____ SS# _____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Add <input type="checkbox"/> 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 fax completed form to
1-833-947-2762 or Email to
cotretiree@humana.com

* Payment is not required, you will receive
a monthly invoice

Please select your plan:		
DHMO HS195 Plan		
Retiree	<input type="checkbox"/>	\$13.62
Retiree + One	<input type="checkbox"/>	\$26.97
Retiree + Family	<input type="checkbox"/>	\$47.94
PPO Plan		
Retiree	<input type="checkbox"/>	\$31.00
Retiree + One	<input type="checkbox"/>	\$58.00
Retiree + Family	<input type="checkbox"/>	\$96.00