HUMANA. CompBenefits

Group Name: Missouri State Government **Benefits Enrollment Form**

NEW ENROLLMENTS ONLY – IF YOU ARE NOT MAKING CHANGES, YOU DO NOT NEED TO COMPLETE THIS FORM. IF YOU ARE MAKING CHANGES, PLEASE SEE BOTTOM OF PAGE.

Social Security No.	Last Name	First Name	Middle	Date of Birth

Home Address	Home Phone	Gender

City	State	Zip	Business Phone	Dental Facility – DHMO Only

List all Your Eligible Dependents That Are To Be Covered

First MI Last		
Spouse:	Gender: M F	Birth Date / /
Child:	Gender: M F	Birth Date / /
Child:	Gender: M F	Birth Date / /
Child:	Gender: M F	Birth Date / /
Child:	Gender: M F	Birth Date / /

Effective Date:	Agent Number: 0603123MO	Group Number:	**DEPARTMENT NAME – REQUIRED**

These plans are not sponsored by the State and are not affiliated with the State MCHCP Plans.

Please Circle Your Choices (Per Pay Period)	Advantage AVN2 Dental Group #461805	Select 35 DHMO Dental Group #460010	VisionCare Plan Group #VS5854
Employee Only	☐ $12.20	☐ $6.83	☐ $3.55
Employee + Spouse	☐ $24.97	☐ $11.59	☐ $5.65
Employee + Child(ren)	☐ $25.36	☐ $11.59	☐ $5.74
Employee + Family	☐ $41.70	☐ $16.02	☐ $8.76

SAM II Effective Date: 12/16/2014
Coverage Effective Date: 1/1/2015
Application Deadline: 10/31/2014

Enrollment Questions: **800-407-6054**
Andy Foley, LB Group Benefits, LLC
111 Westport Plaza Dr., 6th Floor, St. Louis, MO 63146
Email forms to: Burton-Liese@mediacombb.net

Benefit Questions:
Cheryl Hennicke, Humana CompBenefits
314-238-2551

To verify receipt of your application, please call 800-407-6054

IF electing the DHMO Select 35 Plan you must select a Dental Facility. Please note the facility # here_____

I wish to enroll in the dental and/or vision plans indicated above as offered through my employer. 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. I understand that this is a minimum one (1) year contract and that all necessary dental and/or vision services will be provided in the description of benefits and surcharges. I have received and understand the outline of coverage.

Signature: X_____Date_____

CHANGES ONLY **Please fax all changes to Andy Foley at 314-754-9922.**

Subscriber Name: _____Social Security number_____

Effective Date: _____ Policy Number: 460010 – DHMO; 461805-AVN2; VS854- Vision (Circle One)

Add Dependents Name: _____Birth Date__/__/__ Gender:___ Male___ Female
Name: _____Birth Date__/__/__ Gender:___ Male___ Female

Delete Dependents Name: _____Birth Date__/__/__ Gender:___ Male___ Female
Name: _____Birth Date__/__/__ Gender:___ Male___ Female

Terminate Policy (Reason)_____Effective Date:_____
Reinstate Policy (Reason)_____Effective Date:_____

Signature:_____Date:_____

To locate a provider, visit the website www.compbenefits.com