Humana Dental and Vision Enrollment Form

Please Complete: Date of Hire (MM/DD/YYYY)_____				Division: 18
Social Security #	Last Name First Name MI			Date of Birth
Home Address			Home or Cell Phone	Gender
City	State	ZIP Code	Alternate Phone	extension:

List All Your Eligible Dependents That Are To Be Covered

	First MI Last	Sex	Date of Birth
Spouse:		M☐ F☐	
Child:		M☐ F☐	
Child:		M☐ F☐	
Child:		M☐ F☐	
Child:		M☐ F☐	

# of Dependents:	E-mail:	1st Bank Draft Date: _____
Group # **790758**	Agent Code **1024303**	Policy Effective Date:

Prior Coverage: Yes☐ No☐ Carrier Name_____

Coverage Start Date_____ Coverage End Date _____

Coverage Level: Single☐ EE+1☐ Family☐

**Dental and Vision Benefit Coverage is for a 12 month period

Please check your choice. **DHMO C250Z Available only for current DHMO members

Dental - PPO $1,500 w/o Ortho
Monthly Bank Draft
☐Single: $39.77
☐EE+1: $74.13
☐EE+Family: $104.01

Dental - ADV+3S Plan
Monthly Bank Draft
☐Single: $25.20
☐EE+1: $47.09
☐EE+Family $66.12

Dental - PPO $1,000 w/Ortho
Monthly Bank Draft
☐Single: $34.58
☐EE+1: $64.46
☐EE+Family $90.44

Vision
Monthly Bank Draft
☐Single: $8.47
☐EE+1: $20.49
☐EE+Family $23.90

Send to: **Dennis Krol Insurance**
P.O. Box 1818, Frankfort, KY 40602-1818
Go Online: **www.denniskrolinsurance.com**

Or fax to: 502-875-3615
Or call: 502-875-3477
Email to: krolinsurance@bellsouth.net

Authorization

ELECTRONIC FUNDS AUTHORIZATION FORM *(Attach voided check or copy)*

Name of Financial Institution (Bank)_____

Street Address_____**City**_____**State**_____ **Zip Code**_____

Routing Number_____ **Account Number**_____ ☐ **Checking Account** ☐ **Savings Account**

I hereby authorize and direct you to honor and charge to my account checks drawn on my account by and payable to Humana Insurance Company. The signatures on such checks may be typed or printed. You shall have no liability for the return unpaid of any such check if the balance in my account is insufficient to pay the same upon presentation. This authorization shall continue in force until revoked by me in writing, a copy of which revocation shall be sent to Humana Insurance Company.

***ON THE _____DAY OF THE MONTH (Must be the 1st thru 10th) Please check bank records for correct deductions.**

Signature of Premium Payor EXACTLY as it appears on bank records:_____

Any person who knowingly and with intent to defraud any insurance company, or other person, files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime.

Applicant's Signature:_____ Date:_____

KYHJR6BEN