

Dental/Vision Enrollment Form

Dental & Vision Plans

Beginning January 1, 2021, FSRBC will only be offering Dental and Vision coverage as part of the non-medical offerings. In addition, the vision carrier will be changing from Davis Vision to Humana. Humana will direct bill for both Dental and Vision.


ENROLLMENT DENTAL PLANS VISION PLANS BILLING FAQs

How to Enroll

Enrollment in a FSRBC Humana Dental or Vision Plan can be completed independently online, or by sending an enrollment form to Humana for processing.


To enroll online:

- Visit <https://slservices.humana.com/enrollmentregistration/sfallogin.aspx>; enter either login credentials applicable below, check the CAPTCHA and proceed with securely enrolling online.
- Non-Registered Users will securely authenticate your enrollment with your SSN, date of birth, and zip code
- Registered Users—if already enrolled with Humana and previously registered at My-Humana.com, you can login with your user ID and password.

 **To enroll via enrollment form:**

- [Download the form](#)
- Once the form is completed it can be sent to Humana through email at: NFLOpenEnrollment@humana.com

For assistance with the online enrollment call the Humana Pre-Enrollment Hotline at 1-888-393-6765. Open from 8:00am —8:00pm, Monday through Friday, Eastern time

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These are instructions to help you complete the Dental and Vision Enrollment Form. You can access the enrollment form at www.myfsrbc.com under the Dental & Vision section.

First, scroll down to the “How to Enroll” section. Where it says “To enroll via enrollment form”, click on the link to open and download the form.

Dental/Vision Enrollment - Option 2: Enrollment Form

Download the fillable form and complete it – it has been pre-populated for your convenience.

The form is multi-purpose and can be used to enroll in only Dental, only Vision, or both Dental and Vision plans.

Large Group 51+ Employee and Individual Application and Enrollment Form FLORIDA

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in the Large Group Employee and Individual Application and Enrollment Form as "Humana".

Dental and Vision plans insured or administered by Humana Insurance Company.

Print clearly and completely fill in each applicable circle.

Employer / Group name Employer / Group city State
Florida School Retiree Benefits Consortium #735974 FL

Qualifying Event Instructions		Office use only
<input type="radio"/> New business enrollment	<input type="radio"/> Open Enrollment event	Qualifying event date (MM/DD/YYYY)
<input type="radio"/> New hire/Newly eligible	<input type="radio"/> Rehire/Reinstatement	Benefit effective date (MM/DD/YYYY)
<input type="radio"/> Dependent birth or adoption	<input type="radio"/> Marital status change	
<input type="radio"/> Loss of coverage	<input type="radio"/> Other	

In the "Employer/Group City" field, enter your District's county name

You can skip the section labeled Qualifying Event Instructions



Once you download the form, you'll see that many fields have been pre-populated for your convenience. You can use this form to enroll in only Dental, only Vision, or both Dental and Vision. We'll walk you through the remainder of the form now.

At the top of the form, you'll see that FSRBC has already been filled out in the Employer/Group Name field. You will need to complete the "Employer/Group City" field with the name of your District. This doesn't have to be the full formal name of your District – it can simply be the name of the county. For example, you can simply put in "Putnam" or "Washington" rather than the full School District name.

You can skip the Qualifying Event Instructions box completely.

Dental/Vision Enrollment - Option 2: Enrollment Form

Employee / Individual information

Last name First name MI

Social Security Number Date of birth (MM/DD/YYYY) Area code Phone number

Street address

Apt / Suite / PO box number Gender Female Male Language of choice English Spanish

City State Zip code County / Parish

E-mail address

Are you actively at work? Yes No If not, reason: Date of full-time hire (MM/DD/YYYY)

Retiree DBRA Other:

Do you have a disability that affects your ability to communicate or read? No Yes

Are you disabled or unable to perform normal work activities? No Yes If yes, indicate reason:

Annual salary \$ Hours worked per week

Occupation

You can skip the fields highlighted in yellow

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Next, you'll enter your personal information, such as Name, Social Security Number, Date of Birth, and your phone number and mailing address. You can skip the fields highlighted in yellow:

- Are you actively at work?
- Date of full time hire
- Annual salary
- Hours worked per week and
- Occupation

Dental/Vision Enrollment - Option 2: Enrollment Form

Dependent information

Enter information for each covered dependent, including spouse.

1 Dependent last name First name MI Gender Female Male

Social Security Number Date of birth (MM/DD/YYYY) Relationship Spouse Child Other:

Dependent status (if applicable): Full-time student Disabled If disabled, indicate reason:


Use the following alternate address for these dependents: 1 2 3 4

Street address Apt / Suite / PO box number

City State Zip code County

You can add up to 4 dependents

Dependents can have a different address than you


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Next, you'll complete your family information and add any dependents you may have. You can add up to four dependents (we've only shown the information here for one) and you can have a separate address for your dependents, if you'd like.

Dental/Vision Enrollment - Option 2: Enrollment Form

Dental

1 Coverage type: Employee / Individual only
 Employee / Individual & spouse
 Employee / Individual & child(ren)
 Family
 Other

Office use only
Group #
Benefit #
Class/Div #

2 Plan name *****Select one Plan name - High PPO, Middle PPO, Low PPO, DHMO High, DHMO Low**

3 Within the past 12 months, have you or any covered family individual had any dental or orthodontia coverage, such as a spouse's dental coverage? Yes No If yes, list all: (This section must be completed for Humana to process any dental claims)

Current dental carrier name: Orthodontia coverage? Yes No Starting date (MM/DD/YYYY) End date, if applicable (MM/DD/YYYY)

Coverage Type (check all that apply) Employee / Individual Spouse Child(ren)

Prior dental carrier name: Orthodontia coverage? Yes No Starting date (MM/DD/YYYY) End date, if applicable (MM/DD/YYYY)

Coverage type check all that apply) Employee / Individual only Employee / Individual and spouse
 Employee / Individual and child(ren) Family

4 DHMO

	Employee primary care dentist name	Dentist ID #	Current patient?
1 DHMO	<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No
2 DHMO	<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No
3 DHMO	<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No

Select the name of the plan you want to enroll in by circling, highlighting, or typing it out

This entire section is required only if you want to enroll in a DHMO plan

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Next, if you want to enroll in a Dental plan, you'll complete the Dental section shown here.

First, you'll indicate the level of coverage you want - just you, you and your spouse, you and a child or children, or you and your family)

Second, you'll circle, highlight, or type in the name of the plan you want to enroll in (all plan options are shown here)

Third, you'll indicate If you or your family members have had orthodontia coverage in the past year and, if so, provide some additional detail regarding that coverage.

And, finally, if you want to enroll in a DHMO plan, you'll list the primary care dentist you've chosen here. If you are currently enrolled in a PPO plan or want to enroll in a PPO plan, you do not need to complete this section.

Dental/Vision Enrollment - Option 2: Enrollment Form

Vision

1 Coverage type: Employee / Individual only
 Employee / Individual & spouse
 Employee / Individual & child(ren)
 Family
 Other

Office use only											
Group #	Benefit #	Class/Div #									
7 3 5 9 7 4											

2 Plan name **Select one Plan name - Vision High or Vision Low ← Select the name of the plan you want to enroll in by circling, highlighting, or typing it out

Waiver (refusal of coverage)

3 I hereby waive coverage for (check all that apply):

Dental for: <input type="radio"/> Myself <input type="radio"/> My spouse <input type="radio"/> My dependent child(ren) Vision for: <input type="radio"/> Myself <input type="radio"/> My spouse <input type="radio"/> My dependent child(ren)	I decline to apply for group coverage because of: <input type="radio"/> Spousal coverage <input type="radio"/> Medicare supplement <input type="radio"/> Individual coverage <input type="radio"/> Coverage under another carrier's plan provided by my employer / group <input type="radio"/> Other:
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Signature - Please sign below if enrolling or waiving any group coverage

4 Any person who knowingly and 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.

Employee / Individual or legal representative signature Date

Name and relationship of legal representative (if a covered dependent)

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After completing, save the form and email it
 to NFLOpenEnrollment@humana.com

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Next, if you want to enroll in Vision, you'll complete the Vision section. Like with Dental, you'll choose what level of coverage you want and indicate the plan name you want to enroll in.

After that section, there will be two brief Acknowledgement and Authorization sections you'll need to read through, which we haven't shown here.

You'll then indicate if you're waiving either Dental or Vision coverage and select why.

Then, at the bottom of the page, you'll sign and date the form.

Once you've completed the form and enrolled in the plans you'd like, save the enrollment form you've completed and then email this form to the email address listed here.