

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://sfservices.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 **if you want to waive coverage**. You can access the enrollment form at www.myfsrbc.com under the Dental & Vision section.

First, scroll down to the “How to Waive Coverage” section. Where it says “To waive via enrollment form”, click on the link to open and download the form. These instructions are also posted in the same section.

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 [redacted] 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 | [redacted] |
| <input type="radio"/> Dependent birth or adoption | <input type="radio"/> Marital status change | Benefit effective date (MM/DD/YYYY) |
| <input type="radio"/> Loss of coverage | <input type="radio"/> Other [redacted] | [redacted] |

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 some fields have been pre-populated for your convenience. You can use this form to waive 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

FSRBC FLORIDA SCHOOL RETIREE BENEFITS CONSORTIUM

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3

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:

You can add up to 4 dependents

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

Street address Apt / Suite / PO box number

City State Zip code County

Dependents can have a different address than you

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

Vision

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 | | | | | | |

Plan name

Waiver (refusal of coverage)

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

Dental for: Myself My spouse My dependent child(ren)
Vision for: Myself My spouse My dependent child(ren)

I decline to apply for group coverage because of:

Spousal coverage
 Medicare supplement
 Individual coverage
 Coverage under another carrier's plan provided by my employer / group
 Other:

Signature - Please sign below if enrolling or waiving any group coverage

2 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)

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

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Select who you're waiving coverage for on the applicable line(s) of coverage

Type your name in the bottom field and date the form

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

Then, at the bottom of the page, you'll "sign" the form by typing your name and entering the and date.

Once you've completed the form and waived the plans you'd like, save the enrollment form you've completed and then email this form to the above email address (NFLOpenEnrollment@humana.com). You can also mail the form to the following address:

Humana

14260 West Newberry Road, #183
Newberry, Florida 32669