



# Humana Dental/Vision Application

Effective Date \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_

Email Address \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

Spouse Name \_\_\_\_\_ Spouse SS# \_\_\_\_\_ Spouse DOB \_\_\_\_\_

Child Name \_\_\_\_\_ Child SS# \_\_\_\_\_ Child DOB \_\_\_\_\_

Child Name \_\_\_\_\_ Child SS# \_\_\_\_\_ Child DOB \_\_\_\_\_

Child Name \_\_\_\_\_ Child SS# \_\_\_\_\_ Child DOB \_\_\_\_\_

Child Name \_\_\_\_\_ Child SS# \_\_\_\_\_ Child DOB \_\_\_\_\_

**(Check One Plan Below)**

**Traditional Preferred INFS - Unlimited Plan** \_\_\_\_\_

**Traditional Preferred U&C -\$1500** \_\_\_\_\_

EE \$28.79

EE \$34.76

EE+1 \$64.33

EE +1 \$77.17

EE +2 or More: \$100.56

EE +2 or More: \$119.89

**Vision Plan** Yes \_\_\_\_\_ No \_\_\_\_\_ **(Check yes or no & circle the coverage option.)**

EE \$6.65

EE + 1 \$13.31

EE + 2 or More

\$17.83

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date