HumanaVision

Vision Plan Enrollment Form

Alachua County Government

Please complete the following information				
Social Security No.	Last Name		First	Middle
Home Address			Home Phone	Gender
City	State	Zip Code	Business Phone	Date of Birth

List All Your Eligible Dependents To Be Covered			
First MI Last Name	Social Security No.	Gender	Date of Birth
Spouse:		M☐ F☐	/ /
Child:		M☐ F☐	/ /
Child:		M☐ F☐	/ /
Child:		M☐ F☐	/ /
Child:		M☐ F☐	/ /
Child:		M☐ F☐	/ /
Child:		M☐ F☐	/ /

Effective Date	Date of Hire	Email

Monthly Rates:

Employee Only	$ 5.76
Employee and One Dependent	$11.50
Employee and Family	$21.46

I wish to enroll in the plan indicated above as offered through my employer. I understand that this is a minimum one (1) year contract. 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.

Signature: _____ Date: _____