Do you elect the Health Savings Account?  O Yes No If no, complete waiver section	Office use only Group # Benefit # Class/Div #
If you have medical coverage under another pla you may not be eligible for an HSA. Please check with your tax advisor for details.	
	sheet to calculate your maximum allowed contribution. You can find additional are Quick Link for Spending Account information on the member page.
Beneficiary for this account will be the employed administers the HSA once the account is established.	e / individual 's estate. You may change beneficiary information on file with the bank that shed.
Flexible Spending Account (FSA)	
Do you elect the flexible health account?  O Yes No If no, complete waiver section	Office use only Group # Benefit # Class/Div #
Annual amount elected: \$ .00	FSA HC
Start date (MM/DD/YYYY) End da	ite (MM/DD/YYYY)
Do you elect the flexible dependent health	Office use only
account? O Yes O No If no, complete waiver section	Group # Benefit # Class/Div #
Annual amount elected: \$ .00	FSA DC
Start date (MM/DD/YYYY) End date (I	MM/DD/YYYY)
/ / /	
Dental Asia of the State of the	September 1997 Septem
Coverage type: Employee / Individual only	Office use only
O Employee / Individual & spo O Employee / Individual & chi	ouse Group# Benefit# Class/Div#
	ouse Group# Benefit# Class/Div#
O Employee / Individual & chill O Family O Other	ouse Group# Benefit# Class/Div#
O Employee / Individual & chill O Family O Other  Plan name	Pouse Id(ren)  Group #  Benefit #  Class/Div #  Class/Div #  T Y H M O 1 6 0 P T 1 7 2  Pered family individual had any dental or orthodontia coverage, such as a spouse's dental
O Employee / Individual & chill O Family O Other  Plan name  I L 1 0 05 M P C  Within the past 12 months, have you or any coverage?  Yes O No If yes, list all: (This sect Ortho	Benefit # Class/Div # Class/Di
Plan name  I L 1 0 05 IMP C  Within the past 12 months, have you or any cov coverage?  Yes O No If yes, list all: (This sect Orthocoverage)  Current dental carrier name:  Current dental carrier name:	Puse Id(ren)  Group #  Benefit #  Class/Div H  Class/Div #  Class/Div #  Class/Div #  Class/Div H  Class/Div H  Class/Div
O Employee / Individual & chilo Family O Other  Plan name  I L 1 0 05 M P C  Within the past 12 months, have you or any cov coverage? Yes O No If yes, list all: (This sect Ortho Current dental carrier name: cover	Benefit # Class/Div #  TYHMO160PT172  Greed family individual had any dental or orthodontia coverage, such as a spouse's dental ion must be completed for Humana to process any dental claims)  Starting date End date, if applicable (MM/DD/YYYY)  GROOF OI / OI / 2020 II 2/3 I/2020
Plan name  ILIOOSIPO  Within the past 12 months, have you or any covcoverage?  Yes O No If yes, list all: (This section of the coverage Type (check all that apply) Employee  Orthor	Benefit # Class/Div #  TYHMO160PT172  Grered family individual had any dental or orthodontia coverage, such as a spouse's dental ion must be completed for Humana to process any dental claims)  Starting date End date, if applicable (MM/DD/YYYY)  SINO OI / OI / 2020 II 2 / 3 I / 2020  Dee / Individual O Spouse O Child(ren)  End date, if applicable  End date, if applicable
Plan name  I L 1 0 05 M P C  Within the past 12 months, have you or any cov coverage? Yes O No If yes, list all: (This sect Orthocoverage Type (check all that apply) Employee  Orthocoverage Type (check all that apply)	Benefit # Class/Div #  TYHMO160PT172  Grered family individual had any dental or orthodontia coverage, such as a spouse's dental ion must be completed for Humana to process any dental claims)  adontia Starting date End date, if applicable (MM/DD/YYYY)  SEN NO OI / OI / 2020 II 2 / 3 I / 2020  Starting date End date, if applicable to be / Individual O Spouse O Child(ren)  Starting date End date, if applicable
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