

HumanaDental DHMO

HumanaDental Primary Care Dentist (PCD) selection/change form

To select a participating network Dentist under the HumanaDental DHMO plan, please complete this form and mail to:

HumanaDental - ERS

P.O. Box 14639

Lexington, KY 40512-4639

Questions? Please call (877) 377-0987

| | | | | |
|---------------------------------|-----------|------------|----------------------|----------------|
| Employee/Retiree Last Name | | First Name | | Middle Initial |
| ERS DHMO group number 538226 | Member ID | | Daytime phone number | |

| Including yourself, list the first and last name of each family member covered under the DHMO | Date of birth | Gender | Dentist name | Dentist ID | Are you a current patient? |
|---|---------------|--|--------------|------------|---|
| | | <input type="checkbox"/> Male <input type="checkbox"/> Female | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | <input type="checkbox"/> Male <input type="checkbox"/> Female | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | <input type="checkbox"/> Male <input type="checkbox"/> Female | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | <input type="checkbox"/> Male <input type="checkbox"/> Female | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | <input type="checkbox"/> Male <input type="checkbox"/> Female | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Signature

Date