

M&M Home Care Enrollment Form



Primary Enrollee Information:

Effective Date: _____

First Name _____ Last Name _____ Middle Initial _____

Member Social Security Number _____ Gender _____

Date of Birth _____ Date of Hire _____ Job Title _____

Home Address _____

City _____ State _____ Zip _____

Email Address _____ Home Phone Number _____

New Enrollment Address Change Add Dependent

Benefit Election:

Dental Election

- Employee Only - \$33.97 monthly
- Employee + Spouse - \$67.95 monthly
- Employee + Children - \$84.05 monthly
- Family - \$129.75 monthly

Vision Election

- Employee Only - \$6.11 monthly
- Employee + Spouse - \$12.21 monthly
- Employee + Children - \$13.07 monthly
- Family - \$20.88 monthly

Spouse Information:

First Name _____ Last Name _____ Middle Initial _____

Spouse Social Security Number _____ Gender _____

Date of Birth _____

Dependent Information:

First Name _____ Last Name _____ Middle Initial _____

Child Social Security Number _____ Gender _____

Date of Birth _____

First Name _____ Last Name _____ Middle Initial _____

Child Social Security Number _____ Gender _____

Date of Birth _____

First Name _____ Last Name _____ Middle Initial _____

Child Social Security Number _____ Gender _____

Date of Birth _____

Enrollee Signature _____

Date _____