Benefits Enrollment Form

Miami Dade College

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

List All Your Eligible Dependents That Are To Be Covered				
First MI Last	Primary Care Dentist	Dental Facility #	Sex	Birth Date
Spouse:			M ☐ F ☐	
Child:			M ☐ F ☐	
Child:			M ☐ F ☐	
Child:			M ☐ F ☐	
Child:			M ☐ F ☐	
Child:			M ☐ F ☐	
Child:			M ☐ F ☐	

Effective Date:	Plan Code:	Group Number

PLEASE CHECK YOUR CHOICE	☐ CS150P	☐ PPO
Employee Only	☐	☐
Employee + Family	☐	☐

Signature: X ______________________________ Date: ______________