PUTNAM-GREENE FINANCIAL CORP.
HEALTH BENEFIT PLAN
ENROLLMENT APPLICATION

Preferred BENEFIT ADMINISTRATORS INCORPORATED
PO BOX 916188, LONGWOOD, FL 32791-6188

Please Print Clearly

COMPANY NAME: Putnam-Greene Financial Corporation **GROUP: 335-_____**

EMPLOYEE NAME: _____ **MEMBER ID #: _____**
(Member ID will be assigned)

RESIDENCE: _____
ADDRESS **CITY** **STATE** **ZIP CODE**

OCCUPATION: _____ **SOCIAL SECURITY # _____**

FULL-TIME EMPLOYMENT DATE: _____ **DATE OF BIRTH: _____** **GENDER: __M / __F**

INDICATE DESIRED COVERAGE BELOW:

MEDICAL COVERAGE

- ☐ **Employee Only**
- ☐ **Employee + Child/Children**
- ☐ **Employee + Spouse**
- ☐ **Employee + Family**
- ☐ **Waive Coverage - Reason: _____**

COMPLETE DEPENDENT INFORMATION ONLY IF YOU WANT DEPENDENT COVERAGE - LEGAL DEPENDENTS ONLY				
Full Name of Dependent	Date of Birth	Gender	Relationship to Employee	Social Security # (Required)

Any other Group Health Plan coverage or Medicare coverage in force? ___ NO (If No, Skip A. through E.)
___ YES (If Yes, Complete A. Through E.)

A. Insurance Co. or Health Plan Name: _____Group #: _____
B. Insurance Co. Telephone Number: _____ Eff. Date: _____
C. Employer through which above Policy is held (if any): _____
D. Name of Policyholder: _____ ___ Single Coverage or ___ Family Coverage
E. If Medicare, is it: ___ Medicare Part A ___ Medicare Part B ___ Due to Disability

Unless otherwise indicated, I hereby request the Group Health Benefits to which I am or may be entitled and authorize required deductions towards the cost, if applicable. I further authorize any physician, medical practitioner, hospital, medical facility, insurance company, government-sponsored health plan or employer having medical information about me or my covered dependents which relates to the diagnosis, treatment and prognosis of any illness or injury to release this information to Preferred Benefit Administrators, Inc. This authorization shall remain in effect as long as I remain covered by the plan.

_____
Employee Signature **Date**

FOR ADMINISTRATIVE USE ONLY	
Effective Date: _____	**Entered in Eldo : _____**
RX Info Entered: _____	**Entered in CIGNA:_____**