L'OREAL TRAVEL RETAIL AMERICAS HEALTH BENEFIT PLAN

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

GROUP ENROLLMENT APPLICATION

Please Print Clearly

GROUP #: 378-_____
Consumer: 001 / Luxury: 002

COMPANY NAME: L'Oreal Travel Retail Americas

EMPLOYEE NAME: _____ MEMBER ID #: _____
(Will be assigned by Claims Administrator)

RESIDENCE: _____
ADDRESS CITY STATE ZIP CODE HOME PHONE #

DATE OF EMPLOYMENT: _____ DATE OF BIRTH: _____ GENDER: __ M / __ F

OCCUPATION: _____ SOCIAL SECURITY #: _____
(SSN will be used for verification purposes only)

INDICATE DESIRED COVERAGE BELOW:

MEDICAL COVERAGE:

- ☐ **Employee Only**
- ☐ **Employee + Child(ren)**
- ☐ **Employee + Spouse****
- ☐ **Family****

** A Supplemental Application for Spouse Medical Coverage MUST be attached to enroll a spouse in the Plan.

MEDICAL PLAN SELECTION

- ☐ **EPO Plan A**
- ☐ **PPO Plan B**

☐ **Waive Coverage - Reason:** _____

Complete Dependent Information ONLY if you want Dependent Coverage – LIST LEGAL DEPENDENTS ONLY

Full Name of Dependent	Date of Birth	Soc.Sec.#	Gender	Relationship to Employee

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. The information provided on this application for coverage is true and accurate to the best of my knowledge.

_____
Employee Signature Date

FOR ADMINISTRATIVE USE ONLY

Effective Date: _____ CIGNA: _____
RX Info Entered: _____ Pre-X End Date: _____