K2 Solutions
Health Benefit Plan
Group Enrollment Application

Preferred BENEFIT ADMINISTRATORS INCORPORATED

PO BOX 916188, LONGWOOD, FL 32791-6188

Please Print Clearly

COMPANY NAME: K2 Solutions, Inc.

DIVISION: ☐ Canine ☐ K2 OPS ☐ SOF-BU ☐ COMM

GROUP: 386-____

EMPLOYEE NAME: ______________________________ **EMPLOYEE ID #:** ____________

MAILING ADDRESS: ____

ADDRESS CITY STATE ZIP CODE PHONE #

FULL-TIME EMPLOYMENT DATE: __________ **DATE OF BIRTH:** ________ **GENDER:** ☐M / ☐F

TITLE: ______________________ **SOCIAL SECURITY NUMBER:** ________________

(Will be used for identification purposes and Federal reporting only)

AVERAGE HOURS WORKED PER WEEK: __________ **E-MAIL ADDRESS:** _______________

INDICATE DESIRED MEDICAL COVERAGE BELOW:

Medical Coverage	Medical Plan	PPO Network
☐ Employee Only	☐ Base Plan	☐ MedCost PPO (For North & South Carolina employees)
☐ Employee & Spouse	☐ Buy-Up Plan	☐ First Health PPO (For employees of all other states)
☐ Employee & Child(ren)		
☐ Employee & Family		

☐ **Waive Medical Coverage (Reason:** ____**)**

COMPLETE DEPENDENT INFORMATION ONLY IF YOU WANT FAMILY COVERAGE *LIST LEGAL DEPENDENTS ONLY*

Full Name of Dependent	Date of Birth	Gender	Relationship to Employee	Social Security #

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.

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Employee Signature **Date**

FOR ADMINISTRATIVE USE ONLY	
Effective Date: ____________	Entered By: ________
RX Info Entered: __________	Pre-X End Date: ________