SLA Management, LLC
Minimum Essential Coverage Plan
Group Enrollment Application

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

Please Print Clearly

COMPANY NAME: SLA Management, LLC **GROUP: 430**

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

MAILING ADDRESS: _____
ADDRESS **CITY** **STATE** **ZIP CODE** **PHONE #**

DATE OF EMPLOYMENT: _____ **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

- ☐ **Employee Only**
- ☐ **Employee & Spouse**
- ☐ **Employee & Child(ren)**
- ☐ **Employee & Family**
- ☐ **Waive Medical Coverage (Reason:** _____)

Medical Plan (First Health PPO; www.FirstHealthLBP.com)

- ☐ **Minimum Essential Coverage Plan (Preventive Care Benefits Only)**

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 #

Is there 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 By:** _____

RX Info Entered: _____