City of Martin Health Benefit Plan

Group Enrollment Application

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

Please Print Clearly

Group: 434

Employer: City of Martin, TN

- ☐ General Fund (001)
- ☐ Water Dept (002)
- ☐ Sewer Dept (003)
- ☐ Gas Dept (004)
- ☐ All Other Depts. (005)
- ☐ Solid Waste Dept (006)

Employee Name: _____ **Member ID #:** _____
(Will be assigned by Claims Administrator)

Address: _____
Street Address City State Zip Code Telephone #

Date of Full-time Employment: _____ **Date of Birth:** _____ **Gender:** ☐ M / ☐ F

Occupation: _____ **Social Security Number:** _____
(Will be used for identification purposes and Federal reporting only)

Indicate Desired Coverage Below:

Medical Coverage:

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

Cigna.
www.Cigna.com

Complete Dependent Information ONLY if you are electing Dependent Coverage

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

Is there 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: _____ Eldo: _____
RX: _____ Cigna: _____