

KemPharm, Inc. Health Benefit Plan Group Enrollment Application



PO BOX 916188, LONGWOOD, FL 32791-6188

Please Print Clearly

COMPANY NAME: KemPharm, Inc.

GROUP #: 437

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: _____)

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: _____	