Ally Building Solutions
Health Benefit Plan
Group Enrollment Application

Preferred BENEFIT ADMINISTRATORS INCORPORATED

PO BOX 916188, LONGWOOD, FL 32791-6188

Please Print Clearly

Company Name: Ally Building Solutions, LLC **Group #:** 442

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**

Position: _____ **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 ***

Medical Plan:

- ☐ **$500 Deductible Plan**
- ☐ **$2500 Deductible Plan**
- ☐ **$3500 Deductible Plan**

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***Important note:** Working spouses with access to employer sponsored medical coverage are not eligible for coverage, nor are spouses covered under any health insurance policy, including Medicare. Supplemental Spouse Application is required to add spousal coverage.

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

Complete Dependent Information ONLY if you want to cover your Dependents				
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: _____ Cigna: _____