Westbrook Service Corporation
Health Benefit Plan
Group Enrollment Application

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

Please Print Clearly

Company Name: Westbrook Service Corporation **Group #:** 449

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

****Your spouse is not eligible for coverage under this Plan if:**
- Your spouse is *eligible* for medical coverage, or *enrolled* in medical coverage, through his/her own employer's plan; or
- Your spouse is *eligible* for Medicare, or *enrolled* in Medicare, based on age or disability.

Complete Dependent Information ONLY if you are enrolling for Family Coverage

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: _____
Eldo: _____ RX Info Entered: _____