Butson Hotel
Minimum Essential Coverage Plan
Enrollment Application ~ Group #: 454

Preferred Benefit Administrators Incorporated

PO Box 916188, Longwood, FL 32791-6188

Please Print Clearly

Employer Name:
- ☐ Butson Hotel Investments DE (001)
- ☐ Butson White River Junction (002)
- ☐ Butson White River Junction II (003)
- ☐ Butson Middlebury (004)
- ☐ Butson Rutland (005)
- ☐ Bee Ridge Hospitality (006)

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

Mailing Address: _____
Street City State Zip Code Phone #

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)

Average Hours Worked each Week: _____ **E-mail Address:** _____

Indicate Desired MEC Medical Coverage Below:

MEC Medical Coverage
- ☐ Employee Only
- ☐ Employee & Child(ren)

First Health Network
www.FirstHealthLBP.com

Waive Medical Coverage (Please provide reason for waiver)
- ☐ Covered under spouse's plan
- ☐ Covered through Exchange / Healthcare.gov
- ☐ Covered by Medicare
- ☐ Covered by Medicaid
- ☐ Other reason: _____

Complete Dependent Information ONLY if you want to Cover Children *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 MEC 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: _____