American Traveler Staffing Professionals Preventive Benefit Plan

Enrollment Application ~

Preferred Benefit Administrators Incorporated

PO Box 916188, Longwood, FL 32791-6188

Please Print Clearly

Employer Name: American Traveler Staffing Professionals, LLC **Group #:** 457

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 Preventive Benefit Plan Coverage Below:

Preventive Medical Coverage

- ☐ Employee Only
- ☐ Employee & Spouse
- ☐ Employee & Child(ren)
- ☐ Employee & Family

First Health Network

www.FirstHealthLBP.com

☐ Waive Preventive Benefit Coverage / Please note reason for waiver: _____

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 Preventive Plan 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: _____