Mark Kaufman Roofing
Health Benefit Plan
Group Enrollment Application

Preferred Benefit Administrators Incorporated
PO Box 916188, Longwood, FL 32791-6188

Please Print Clearly

Employer Name: Mark Kaufman Roofing **Group #:** 458

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 Weekly: _____ **E-mail:** _____

Indicate Desired Medical Coverage Below:

Medical Coverage:

- ☐ **Employee Only**
- ☐ **Employee & Spouse***
- ☐ **Employee & Child(ren)**
- ☐ **Employee & Family***
- ☐ **Waive Medical Coverage (Reason:** _____**)**

Note: Working spouses with access to employer sponsored medical coverage are not eligible for coverage through this Plan, nor are spouses covered under any health insurance policy, including Medicare.

First Health Network
www.MyFirstHealth.com

Family Members to be Enrolled				
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 Entered: _____