BrewBurgers
Minimum Essential Coverage Plan
Enrollment Application

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

Please Print Clearly

Group #: 466

Company Name: BrewBurgers

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

Mailing Address: _____
Address City State Zip Code Phone #

Date of Full-Time Employment: _____ **Date of Birth:** _____ **Gender:** ☐**M** / ☐**F**

E-mail Address: _____ **Social Security Number:** _____
(Will be used for identification purposes and Federal reporting only)

Indicate Desired Coverage Below:

MEC Benefit Plan (Preventive Care Benefits Only)

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

Note: All medical care must be performed by Coastal Family Medicine (CFM). First Health Limited Benefit PPO Network Providers may be used if CFM is unable to perform service. **Locate network providers at www.FirstHealthLBP.com**

Complete this section to cover dependents through the MEC Plan

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 MEC 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: _____