

GROUP NAME: Dustin's BBQ
GROUP #: E77

Employer Section:						
Date of Hire: _____	Effective Date: _____			Division: _____		
Dental Option	Circle One:	High	Low			
	Single _____	Emp + Spouse _____	Emp + Child _____	Family _____	Waived _____	
Vision Election	Single _____	Emp + Spouse _____	Emp + Child _____	Family _____	Waived _____	

EMPLOYEE INFORMATION

Social Security Number		Last Name		First Name		MI	Male / Female
Email Address							
Street Address				Marital _____ Single _____ Divorced _____ Status: _____ Married _____ Other _____		Date Of Birth	
City		State	Zip	Hours Worked Per Week		Phone Number	

COVERAGE ELECTION (please circle)

MEDICAL PLAN 1	Single	Employee + Spouse	Employee + Child	Family
MEDICAL PLAN 2	Single	Employee + Spouse	Employee + Child	Family
_____ I WAIVE ALL MEDICAL COVERAGE – Please sign below.				

DEPENDENTS (enrolling in plan)

	Sex	Last Name	First Name	M.I	Birth Date	Social Security Number	Other Insurance
Spouse	M/F						Y/N Fill In Below Table
Child	M/F						Y/N Fill In Below Table
Child	M/F						Y/N Fill In Below Table
Child	M/F						Y/N Fill In Below Table

This section must also be filled out for anyone having other coverage, including Medicare coverage

OTHER COVERAGE INFORMATION

Name of Covered Person	Effective Date	Name of Carrier	Name of Policy Holder

(1) I am enrolling for the benefits indicated in the "Coverage Election" section. If required, I authorize deductions from my earnings. (2) By completing the "Waiver of Coverage", I understand I am refusing coverage and that there may be penalties if I decide to reapply at a later date. (3) I hereby authorize any licensed physician, hospital, clinic, or other medical or medically related facility, insurance company, the Medical information Bureau, or other organization, institution, or person, that has any records or knowledge of me and/or my dependents' health, to give to Lucent Health Company or the reinsurer any such information. (4) I also authorize Lucent Health or the reinsurer to release any information regarding me and/or my dependents to the Medical Information Bureau and to other carriers through which I have policies or to whom I may apply or to whom a claim for benefits may be submitted. (5) I hereby certify that all the information shown above is true and correct to the best of my knowledge. I also understand that any false information listed will nullify this application and the coverage for which I am applying. Lucent Health Company has the right to rescind coverage should the above information prove to be not complete or accurate.

Employee Signature _____ Date _____

Employer Signature _____ Date _____