Lucent Health
P O Box 7020 Appleton, WI 54912 Phone: 877-236-0844 Fax: 866-542-1874

ENROLLMENT FORM

GROUP NAME: Gator's Dockside Group, Inc. **GROUP #: E76**

Employer Section:
Date of Hire: _____ Effective Date: _____ Division: _____
Dental Option: 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

OTHER COVERAGE INFORMATION

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

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_____