Enrollment Form

Name of Group (Employer) _____

Employee Name: _____

Employee Social Security Number: _____

Employee Gender: _____

Employee Date of Birth: _____

Employee Address:_____
_____

Type of coverage selected:

_____Employee only

_____Employee plus dependents

Dependent Name: _____

Dependent Date of Birth: _____

Dependent Name: _____

Dependent Date of Birth: _____

Dependent Name: _____

Dependent Date of Birth: _____

_____ Waive Coverage

_____
Employee Signature

Please return this form to your benefits administrator, Molly Reinmann via fax: 800-789-7326 or email: molly@lfgben.com

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