DUPRÉ LOGISTICS, LLC INSURANCE INQUIRY FORM

Please have your spouse & his/her employer complete this form.

Dependent Name: _____

TO BE COMPLETED BY THE ABOVE LISTED DEPENDENT:

I authorize my employer to release this information on my behalf.

Signature of dependent*:_____ Date: _____

TO BE COMPLETED BY THE ABOVE LISTED DEPENDENT'S EMPLOYER:

Dear Employer,
Your cooperation is required to assist in the review of your employee's access to insurance coverage.

Please check ONE appropriate answer:

☐ We offer group medical coverage and this employee is enrolled.
☐ We do not offer group medical coverage to our employees.
☐ We offer group medical coverage and this employee was eligible but did not enroll.
☐ We offer group medical coverage but this is a new employee who will be eligible on __/__/____.
☐ We offer group medical coverage but this employee is part-time and is not eligible.
☐ We offer group medical coverage but this employee is not eligible because (please explain):

_____
_____
_____

My signature is confirmation that the group benefit plan information I have provided above is true and accurate.

Signature of employer representative*: _____ Date: _____

Print representative name: _____ Title: _____

Print employer name: _____ Business Phone: (_____)_____

Address _____ City _____ State _____ Zip _____

*By signing above, you understand that the information submitted to Dupré Logistics will be held confidential and will be subject to disclosure only upon express written authorization or as required by law. You certify under penalty of perjury under the laws of the State of Louisiana that the foregoing is true and accurate to the best of your knowledge. You understand that falsification of information contained in this statement may result in your termination of enrollment in the health care program, and that a civil action may be brought against you for any losses, including reasonable attorney fees and court costs.