DUPRÉ LOGISTICS, LLC INSURANCE INQUIRY FORM

Employee Name: _____

Dependent Name: _____

TO BE COMPLETED BY THE ABOVE LISTED DEPENDENT:

Please select one:

☐ I am unemployed, do not have any other medical insurance, and do not file taxes jointly with my spouse.

☐ Other (please explain):

_____

_____

_____

Signature of employee*: _____ Date: _____

Signature of dependent*: _____ Date: _____

*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.