Total Health Care USA, Inc.
Group Status Verification Form

SEND CORRESPONDENCE TO:
EMAIL: marketing@THCmi.com
FAX: (313) 871-2860

Please verify that the following information is correct. **Indicate changes/corrections or fill in missing information in the space provided.** Forward to Total Health Care USA with a **copy of your most recent Quarterly Wage and Tax Statement filed with the State of Michigan.**

Missing or inaccurate information may result in non renewal of group coverage.

	CURRENT
Group Name/Number:	Group Name:_____ Group Number: _____
Group Address:	Street: _____ City:_____ State:_____ Zip:_____
Group Contact:	Name: _____ Title:_____ Email Address:_____
Agent/Agency of Record:	Agent: _____ Agency of Record:_____
Tax ID:	ID #:_____
SIC Code:	SIC Code: _____
Benefit Plan(s):	❑ HMO ❑ PPN HMO ❑ Select ❑ PPN Select
Employer Contribution Toward Monthly Premium: (Employer contribution must be 50% or more of the single rate)	Single % _____ Double % _____ Family % _____ Sponsored Dependent % _____
Number of Current Waivers:	#:_____
Number of Current Subscribers: **(Enrolled EEs):**	#:_____
Other Employer Sponsored Health Insurance:	Ins. Co.: _____
Organization/Affiliation:	❑ Union Name: _____ ❑ Non-Union Name: _____

	Jan.	Feb.	Mar.	April	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.	TOTAL	AVERAGE
Average Employee Count (for previous 12 months):														

*By signing this I do hereby certify that all statements made by me in this application are true and accurate to the best of my knowledge.

Name of Person Completing Form:_____ Email Address:_____
(Printed) (Printed)

_____ Title:_____ _____
(Signature) (Printed) (Date)