MEMBER STATUS FORM

❑ HMO ❑ PPN HMO
❑ SELECT - POS ❑ PPN Select - POS

GROUP NUMBER_____
Effective Date of Coverage:_____
❑ Hourly ❑ Salary ❑ Union ❑ Non-Union

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

REQUEST FOR: ❑ **Enrollment** ❑ **Deletions** ❑ **Additions** ❑ **Status Changes**

E-mail Address: (Recommended)	Social Security Number:		
Last Name:	First Name:	Middle Name:	
Street Address:	City:	State:	Zip:
Primary Phone:	Work Phone:	Employer:	Hire Date:

MARITAL STATUS
❑ Married ❑ Widowed ❑ Single ❑ Divorced/ Separated

LANGUAGE
❑ English ❑ Other _____

ETHNICITY (OPTIONAL)
❑ Black/Non-Hispanic ❑ White/Non-Hispanic ❑ Hispanic ❑ Other _____

USE THIS SECTION FOR NEW ENROLLEES, ADDITIONS AND CHANGES ONLY

REASON FOR APPLICATION –
Check One and Provide Date of Event

❑ OPEN ENROLLMENT _____ ❑ BIRTH _____ ❑ SPOUSE LOST COVERAGE _____ ❑ COBRA ELECTION _____
❑ COURT ORDER _____ ❑ MARRIAGE _____ ❑ RETURN TO EMPLOYMENT _____ Reason _____
❑ NEW HIRE _____ ❑ PART-TIME TO FULL-TIME _____ ❑ OTHER EVENT_____

List all persons to be covered FIRST NAME/LAST NAME	Relationship	M/F	Date of Birth	Social Security No.	PRIMARY CARE PHYSICIAN	Physician's ID #
	Subscriber				Name: Address:	
	Spouse				Name: Address:	
	Eligible Dependent				Name: Address:	
	Eligible Dependent				Name: Address:	
	Eligible Dependent				Name: Address:	
	Eligible Dependent				Name: Address:	

(IF FAMILY MEMBER'S ADDRESS AND/OR PHONE NUMBER(S) ARE NOT THE SAME AS SUBSCRIBER, PLEASE ATTACH THIS INFORMATION)

COORDINATION OF BENEFITS *(IF YOU HAVE ADDITIONAL HEALTH BENEFITS)*

Are you, your spouse or dependent covered by Medicare? ❑ YES ❑ NO Please list the effective date(s) of coverage: Part A _____ Part B _____
If yes, indicate covered person's name and Medicare number here: _____

Are you, your spouse or dependents covered by any other health insurance in addition to your THC plan? ❑ YES ❑ NO
If yes, complete section below. (Please include any children from a former marriage who are covered by an ex-spouse)

NAME OF PERSON COVERED	NAME OF HEALTH INSURANCE COMPANY	INSURANCE POLICY NO.	EMPLOYER

With whom do the children live? ❑ Mother ❑ Father ❑ Other Is the health insurance court ordered? ❑ YES ❑ NO

USE THIS SECTION FOR DELETIONS ONLY

Reason for Application - *Check One*

❑ OPEN ENROLLMENT ❑ LEFT EMPLOYMENT ❑ INELIGIBLE DUE TO AGE ❑ MOVED OUT OF SERVICE AREA ❑ DEATH
❑ DISABILITY LEAVE ❑ FULL-TIME TO PART-TIME ❑ MEMBER REQUEST ❑ COVERED UNDER SPOUSE ❑ LAYOFF
❑ DIVORCE ❑ OTHER, PLEASE EXPLAIN_____

IS IT YOUR INTENTION TO DELETE THE ENTIRE EMPLOYEE CONTRACT? ❑ YES ❑ NO If "NO," List affected Members

FIRST NAME	LAST NAME	SOCIAL SECURITY NO.	TERMINATION EFFECTIVE DATE

I hereby apply on my behalf of person(s) listed on this application to Total Health Care USA, Inc. for the coverage now being offered. I understand that this application is subject to acceptance by the corporation and the services provided will be subject to verification of eligibility, benefits, limitations and exclusions described in my Total Health Care USA Group Certificate of Coverage and any applicable Riders. I agree to be bound by all terms and conditions of the contract. I understand that I am under no obligation to apply for coverage from Total Health Care USA.

Total Health Care USA, Inc. adheres to all Health Insurance Portability and Accountability Act (HIPAA) of 1996 requirements.
You will be sent a Privacy Notice with your Enrollment materials outlining HIPAA requirements.

_____ _____
APPLICANT'S SIGNATURE DATE EMPLOYER'S SIGNATURE DATE