# MEMBER STATUS FORM

TOTAL HEALTH CARE USA

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

**GROUP NUMBER** XG50541

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: | | | MARITAL STATUS | LANGUAGE |
|---|---|---|---|---|---|
| Last Name: | First Name: | Middle Name: | | ❑ Married ❑ Widowed ❑ Single ❑ Divorced/ Separated | ❑ English ❑ Other _____ |
| Street Address: | City: | State: | Zip: | ETHNICITY (OPTIONAL) | |
| Primary Phone: | Work Phone: | Employer: | Hire Date: | ❑ 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 _____