



Total Health Care USA Group Status Verification Form

SEND CORRESPONDENCE TO:
EMAIL: update@thc-online.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.

CURRENT

UPDATES/CORRECTIONS

Group Name/Number	Group Name: _____ Group Number: _____	Group Name: _____ Group Number: _____
Group Address:	Street: _____ City: _____ State: _____ Zip: _____	Street: _____ City: _____ State: _____ Zip: _____
Group Contact:	Name: _____ Title: _____ Email Address: _____	Name: _____ Title: _____ Email Address: _____
Agent/Agency of Record:	Agent: _____ Agency of Record: _____	Agent: _____ Agency of Record: _____
Tax ID:	ID #: _____	ID #: _____
SIC Code:	SIC Code: _____	SIC Code: _____
Benefit Plan(s):	<input type="checkbox"/> HMO <input type="checkbox"/> PPN HMO <input type="checkbox"/> Select <input type="checkbox"/> PPN Select <input type="checkbox"/> Other	<input type="checkbox"/> HMO <input type="checkbox"/> PPN HMO <input type="checkbox"/> Select <input type="checkbox"/> PPN Select <input type="checkbox"/> Other
Employer Contribution Toward Monthly Premium (Employer contribution must be 50% or more of the single rate)	Single % _____ Double % _____ Family % _____ Sponsored Dependent % _____	Single % _____ Double % _____ Family % _____ Sponsored Dependent % _____
Total Employees:	Full-time: _____ Part-time: _____ Seasonal: _____ Contract: _____	Full-time: _____ Part-time: _____ Seasonal: _____ Contract: _____
Number of Current Waivers:	#: _____	#: _____
Number of Current Subscribers (Enrolled EEs):	#: _____	#: _____
Other Employer Sponsored Health Insurance:	Ins. Co.: _____	Ins. Co.: _____
Organization/Affiliation:	<input type="checkbox"/> Union Name: _____ <input type="checkbox"/> Non-Union Name: _____ <input type="checkbox"/> PEO/ASO Name: _____	<input type="checkbox"/> Union Name: _____ <input type="checkbox"/> Non-Union Name: _____ <input type="checkbox"/> PEO/ASO Name: _____

Name of Person Completing Form: _____ Title: _____
(Printed) (Printed)

(Signature) (Date)