



# MEMBER STATUS FORM

HMO       PPN HMO       Group Coverage       Individual Coverage  
 Effective Date of Coverage: \_\_\_\_\_  
 SELECT - POS       PPN Select - POS      Group Number: \_\_\_\_\_  
 Hourly       Salary       Union       Non-Union

SEND CORRESPONDENCE TO:  
 EMAIL: [marketing@thc-online.com](mailto:marketing@thc-online.com)  
 FAX: (313) 871-2860

REQUEST FOR:     Enrollment     Deletions     Additions     Status Changes

Social Security Number:		E-mail Address:		MARITAL STATUS		LANGUAGE	
Last Name:		First Name:		Middle Name:		<input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> English <input type="checkbox"/> Single <input type="checkbox"/> Divorced/ Separated <input type="checkbox"/> Other _____	
Street Address:		City:		State:		Zip:	
Home Phone:		Work Phone:		Employer:		Hire Date:	
ETHNICITY (OPTIONAL)							
<input type="checkbox"/> Black/Non-Hispanic <input type="checkbox"/> White/Non-Hispanic <input type="checkbox"/> Hispanic <input type="checkbox"/> Other _____							

### USE THIS SECTION FOR NEW ENROLLEES, ADDITIONS AND CHANGES ONLY

Reason for Application – *Check One*

OPEN ENROLLMENT \_\_\_\_\_       BIRTH \_\_\_\_\_       SPOUSE LOST COVERAGE \_\_\_\_\_       COURT ORDER \_\_\_\_\_  
 COBRA ELECTION \_\_\_\_\_       MARRIAGE \_\_\_\_\_       RETURN TO EMPLOYMENT \_\_\_\_\_       OTHER EVENT \_\_\_\_\_  
 NEW HIRE \_\_\_\_\_       PART-TIME TO FULL-TIME \_\_\_\_\_

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

(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  
 If yes, indicate covered person's name and Medicare number here: \_\_\_\_\_ Please list the effective date(s) of coverage: Part A \_\_\_\_\_ Part B \_\_\_\_\_

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 or Individual Health Maintenance Contract 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 \_\_\_\_\_

#### INSTRUCTIONS FOR COMPLETING THIS FORM

- Step 1 Complete all information requested to assure timely and accurate processing of this form.
- Step 2 Be sure to list yourself first, then your spouse (if applicable), and then follow with other eligible family members. Complete first name, middle name, and last name for each member.
- Step 3 Please review your application for correct information, and sign and date the application.
- Step 4 This section is used to indicate members covered by another group health plan or insurance policy.
- Step 5 This section is used for deletions only. Please indicate the reason for the deletion and whether you intend to delete the entire employee contract. If you are not deleting the contract, it is important that you list each member you wish to have removed from the contract.