



**MEMBER STATUS FORM**

- HMO     PPN HMO  
 SELECT     PPN SELECT

**To be completed by Employer**  
 Effective Date of Coverage: \_\_\_\_\_  
 Group Number: \_\_\_\_\_  
 Hourly     Salary     Union     Non-Union

**Mail to:** Total USA Suite 1600  
 3011 W. Grand Blvd.  
 Detroit MI 48202  
 ATTN: Enrollment  
 FAX (313) 871-2860

**REQUEST FOR:**

**Enrollment** \_\_\_\_\_    **Deletions** \_\_\_\_\_    **Additions** \_\_\_\_\_    **Status Changes** \_\_\_\_\_

1	SOCIAL SECURITY NUMBER:	E-MAIL ADDRESS:		
2	LAST NAME:	FIRST NAME:	MIDDLE NAME:	
	STREET ADDRESS:	CITY:	STATE:	ZIP:
	HOME PHONE:	WORK PHONE:	EMPLOYER:	HIRE DATE:

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

Reason for Application – Check One  
 OPEN ENROLLMENT     MARRIAGE     RETURN FROM LAYOFF     BIRTH     SPOUSE LOST INSURANCE COVERAGE  
 COBRA ELECTION     NEW HIRE     PART-TIME TO FULL-TIME     QUALIFYING EVENT \_\_\_\_\_

LIST ALL PERSONS TO BE COVERED FIRST NAME/LAST NAME	RELATIONSHIP	M / F	DATE OF BIRTH	SOCIAL SECURITY NO.	PRIMARY CARE PHYSICIAN	
					LAST NAME	CENTER NO.
	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)

4 PLEASE NOTE: DEPENDENT COVERAGE IS SUBJECT TO VERIFICATION OF ELIGIBILITY    THE PRIMARY CARE PHYSICIAN SECTION MUST BE COMPLETED FOR EACH PERSON BEFORE APPLICATION CAN BE PROCESSED

**5 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

**6 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     LAY OFF  
 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 the benefits, limitations and exclusions described in my Total Health Care USA Group 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**

- Section 1 & 2** Complete all information requested to assure timely and accurate processing of this form.
- Section 3** 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.
- Section 4** Please review your application for correct information, and sign and date the application.
- Section 5** This section is used to indicate members covered by another group health plan or insurance policy.
- Section 6** 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.