

# ENROLLMENT, CHANGE, AND TERMINATION FORM – TRINITY HEALTH PPO, DENTAL, VISION, AND LEGAL

## SECTION 1 – ASSOCIATE INFORMATION

Social Security No.	Name	Gender M      F	Date of Birth (MM/DD/YYYY)	Marital Status <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> Div
Street Address:	Apt #	City	State	Zip
				Home Phone (      )
Relation Codes:    1 – Spouse    2 – Dependent Child (Covered thru end of the year the child turns age 19)		3 – College Student ( age 26)		4 – Step Child
				Work Phone (      )

## SECTION 2 \*\*\*IF YOU CHOOSE PRIORITY HEALTH HMO, YOU MUST COMPLETE A SEPARATE ENROLLMENT FORM\*\*\*

Name of Dependents			Social Security Number	Date of Birth	Gender M or F	Relation Code (See Sec 1)	Trinity Health PPO	Delta Dental	Vision		Hyatt Legal	Effective Date of Coverage (See Sec 4 for termination dates)
First	MI	Last							Standard	Enhanced		
<b>Associate Information Only</b> ⇒ ⇒ ⇒			<b>See Section 1</b>	<b>See Section 1</b>	<b>See Section 1</b>	N/A						
Add Delete												
Add Delete												
Add Delete												
Add Delete												
Add Delete												

<b>SECTION 3 - LIST OTHER COVERAGE HERE:</b>	<b>SECTION 4 – TERMINATING COVERAGE</b> (Check all that apply)
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Insurance Company Name (please attach copy of card)	Type of other coverage: (circle all that apply)  Medical                      Dental                      Vision	List Dependent Names in Section II	Trinity Hlth PPO	Dental	Vision	Legal	Termination Date
Policy Holder's Name:	Are you or your spouse covered by Medicare? Self: Y or No      Spouse: Y or N If yes, you must attach a copy of your card(s) to this application.	Myself					
		My Dependents					

<p>I hereby apply for benefits under the group benefits plan(s) provided by St. Joseph Mercy Port Huron subject to all of its terms, conditions, and provisions. If a contribution towards the cost is required, I authorize the necessary deductions from my earnings. I further authorize and direct that all medical payments be made directly to the hospital, doctor, etc., rendering a medical service payable under this plan. I also authorize any insurance company, prepayment organization, employer, hospital, or physician to release all information with respect to myself or my dependents which may have a bearing on the benefits payable under this or any other plan providing benefit services.</p>	Reason for Termination of Coverage:
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Associate Signature	Date	HR USE ONLY
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