

<b>▶ PERSONAL DATA</b>		SOCIAL SECURITY NUMBER	NAME (First, Middle, Last)	GENDER	BIRTHDATE (M D Y)	<input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED	
STREET ADDRESS		CITY, STATE, ZIP	HOME PHONE (     )	JOB TITLE			<input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED

**▶ YOUR FAMILY**

FIRST	NAME OF DEPENDENTS MIDDLE INITIAL	LAST	SOCIAL SEC. #	DATE OF BIRTH	RELATIONSHIP	RESIDE WITH YOU?	PLEASE INDICATE SELECTION WITH AN "X"						PRIMARY CARE PHYSICIAN SELECTION		
							Advantage HMO	DELTA DENTAL Standard	DELTA DENTAL High	VISION Standard	VISION Enhanced	Legal	PERSONAL CARE PHYSICIAN	PCP CODE	
EMPLOYEE/PRIMARY INDIVIDUAL			SEE ABOVE	SEE ABOVE	SELF	N/A									

**ADDITIONS OR DELETIONS**

FIRST	NAME OF DEPENDENTS MIDDLE INITIAL	LAST	SOCIAL SEC. #	DATE OF BIRTH	RELATIONSHIP	ADD OR DELETE?	PLEASE INDICATE SELECTION WITH AN "X"								
							Advantage HMO	DELTA DENTAL Standard	DELTA DENTAL High	VISION Standard	VISION Enhanced	Legal			

**▼ REFUSAL OF BENEFITS**  
 This is to certify that I have been given the opportunity to examine the group plan benefits available to me and to apply ,and I have decided NOT to apply for the group plan benefits for:  
 Medical  Dental  Vision  Legal  \*Health Care Spending Acct.  \*Dependent Care Spending Acct.  
 \*Min. \$130 and max. \$5,000 per year for both Health Care & Dependent Care Spending Acct.

<p><b>▼ REASON FOR CHANGE/ENROLLMENT</b></p> <input type="checkbox"/> New Hire <input type="checkbox"/> Part-time/Full-time <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Marriage <input type="checkbox"/> Loss of Coverage. <input type="checkbox"/> Transfer. <input type="checkbox"/> Termination <input type="checkbox"/> Reduction of hours <input type="checkbox"/> Lay off <input type="checkbox"/> Divorce/Legal Separation <input type="checkbox"/> Loss of Dependent Status. <input type="checkbox"/> HIPAA Qualifying Event (describe) _____	<p>Per Pay Costs:</p> <p>Medical Cost: \$ _____</p> <p>Dental Cost: \$ _____</p> <p>Vision Cost: \$ _____</p> <p>Legal Cost: \$ _____</p>	<p>Per Year Costs:</p> <p>Health Care Spending Account Cost: \$ _____</p> <p>Dependent Care Spending Account Cost: \$ _____</p>
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Medical  Dental  Vision  Legal  \*Health Care Spending Acct.  \*Dependent Care Spending Acct.  
 \*Min. \$130 and max. \$5,000 per year for both Health Care & Dependent Care Spending Acct.

I understand that future applications may require additional waiting periods, limitations and/or proof of good health at my own expense and that the plan sponsor may reject a future application.

**▼ AUTHORIZATION & ASSIGNMENT**  
 I hereby apply for benefits indicated above under the group benefit plan(s) provided by the Trinity Senior Living Communities 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 understand that the benefits I choose now will stay in effect until such time as I change benefit selection through future open enrollment periods or qualified family or employment status change during the year. 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 benefits or services

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Human Resources Use Only:**  
 DOH: \_\_\_\_\_ Effective Date: \_\_\_\_\_ HRS: \_\_\_\_\_  
 Date entered in: HCBO: \_\_\_\_\_ SMS: \_\_\_\_\_ Health: \_\_\_\_\_