

▶ PERSONAL DATA	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		SOCIAL SEC. #	DATE OF BIRTH	RELATIONSHIP	RESIDE WITH YOU?	PLEASE INDICATE SELECTION WITH AN "X"					
	MIDDLE INITIAL	LAST					PCA	PPO	DELTA DENTAL Standard	DELTA DENTAL High	Vision Standard	Vision Enhanced
EMPLOYEE/PRIMARY INDIVIDUAL	SEE ABOVE		SEE ABOVE	SEE ABOVE	SELF	N/A						

ADDITIONS OR DELETIONS												
FIRST	NAME OF DEPENDENTS		SOCIAL SEC. #	DATE OF BIRTH	RELATIONSHIP	ADD OR DELETE?	PLEASE INDICATE SELECTION WITH AN "X"					
	MIDDLE INITIAL	LAST					PCA	PPO	DELTA DENTAL Standard	DELTA DENTAL High	Vision Standard	Vision Enhanced

▼ 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.

▼ REASON FOR CHANGE/ENROLLMENT <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) _____ <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Legal <input type="checkbox"/> *Health Care Spending Acct. <input type="checkbox"/> *Dependent Care Spending Acct. *Min. \$130 and max. \$5,000 per year for both Health Care & Dependent Care Spending Acct.	Per Pay Costs: Medical Cost: \$ _____ Dental Cost: \$ _____ Vision Cost: \$ _____ Legal Cost: \$ _____	Per Year Costs: Health Care Spending Account Cost: \$ _____ Dependent Care Spending Account Cost: \$ _____
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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: _____