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|------------------------|------------------------|----------------------------|------------------|-----------------------|--|
| ▶ 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 |

▶ YOUR FAMILY

| FIRST | NAME OF DEPENDENTS MIDDLE INITIAL | LAST | SOCIAL SEC. # | DATE OF BIRTH | RELATIONSHIP | RESIDE WITH YOU? | PLEASE INDICATE SELECTION WITH AN "X" | | | | | PLEASE INDICATE SELECTION WITH AN "X" | |
|-----------------------------|--------------------------------------|------|---------------|---------------|--------------|------------------|---------------------------------------|-------------------|-----------------|-----------------|-------|---------------------------------------|--------|
| | | | | | | | DELTA DENTAL Standard | DELTA DENTAL High | Vision Standard | Vision Enahnood | Legal | Add | Delete |
| EMPLOYEE/PRIMARY INDIVIDUAL | | | SEE ABOVE | SEE ABOVE | SELF | N/A | | | | | | | |
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▼ 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

New Hire Part-time/Full-time Open Enrollment Marriage Loss of Coverage. Transfer.
 Termination Reduction of hours Lay off Divorce/Legal Separation Loss of Dependent Status.
 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: \$ _____ |
|--|---|---|

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: WES: _____ SMS: _____ Health: _____