▶ PERSONAL DATA	SOCIAL SECURITY NUMBER	NAME (First, Middle, Last)	GENDER	BIRTHDATE (M D Y)	☐ SINGLE ☐ WIDOWED ☐ MARRIED ☐ SEPARATED ☐ DIVORCED

STREET ADDRESS	CITY, STATE, ZIP	HOME PHONE ( )	JOB TITLE

▶ YOUR FAMILY

NAME OF DEPENDENTS FIRST MIDDLE INITIAL LAST	SOCIAL SEC. #	DATE OF BIRTH	RELATIONSHIP	RESIDE WITH YOU?	PLEASE INDICATE SELECTION WITH AN "X"							PRIMARY CARE PHYSICIAN SELECTION	
					PRIORITY HEALTH	HAP	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

NAME OF DEPENDENTS FIRST MIDDLE INITIAL LAST	SOCIAL SEC. #	DATE OF BIRTH	RELATIONSHIP	ADD OR DELETE?	PLEASE INDICATE SELECTION WITH AN "X"								
					PRIORITY HEALTH	HAP	DELTA DENTAL Standard	DELTA DENTAL Premier	Vision Standard	Vision Enahnced	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.

▼ 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)_______________________________________

☐ 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.

Per Pay Costs:	Per Year Costs:
Medical Cost: $____________	Health Care Spending Account Cost: $______________
Dental Cost: $____________	Dependent Care Spending Account Cost: $__________
Vision Cost: $____________	
Legal 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: *HCBO:* _____________ *SMS:* _____________ *Health:*_________