

Today's Date _____
Worker Initials _____
Civitec # _____
Medifax
IHP

Check One: Enroll Application
 Disenrollment Form
 Update Form
 Replace Card
 Change Group #

TENCON HEALTH PLAN

Enrollment Application/Disenrollment & Update Form

PRINT ONLY

Last Name _____		First Name _____		M.I. _____	
Social Security # _____ - _____ - _____		Birth Date _____		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
Address _____		Apt# _____		City _____ State <u>MI</u> Zip _____	
Home Phone# () _____		Alternate Phone# () _____			
Marital Status <input type="checkbox"/> Single		<input type="checkbox"/> Married		<input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
Race (optional)					
<input type="checkbox"/> Black		<input type="checkbox"/> White		<input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> American Indian <input type="checkbox"/> Other	
Recipient ID (if applicable) _____		Are you a U.S. citizen?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you a college student?		<input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, where do you attend? _____	
Including yourself, how many of your dependents are living in your household? _____					
Total household yearly gross (before taxes) income \$ _____ (do not include income from dependent children)					
NOTE: If you do not have any income, please briefly explain how you support yourself and your family. _____ _____					
Group # Assignment _____		Assignment Location _____			
Comments: _____ _____					

RELEASE OF INFORMATION

I, _____, on _____ authorize District Health Department#10 to release any and all medical information in its possession to healthcare providers who are currently treating me or who are being consulted regarding my treatment, including those providers I may be referred to, as necessary for my medical treatment. In addition, I authorize District Health Department#10 to release any and all medical information in its possession to the Ingham Health Plan for reimbursement purposes, including for the quality of care evaluations, as shall be required by the Ingham Health Plan. This authorization includes all my medical records, including records of mental health and substance abuse services, diagnostic and treatment records related to HIV (human immunodeficiency virus), AIDS (acquired immunodeficiency syndrome), AIDS Related Complex, and hepatitis.

This authorization for release shall be effective for five (5) years from the date of this consent. I may cancel this authorization for release at any time by filing a letter with District Health Department#10 and will be effective on the date of my written request and for any time thereafter. The District Health Department#10 may still release information collected prior to the date of my written request.

I have read and understand this consent and have had any questions related to this consent answered, and agree by signing below.

Signature of Patient or Legal Guardian/Relationship to Patient

Print Name of Signer

Signature of Witness

Print Name of Witness