

LARGE GROUP ENROLLMENT FORM

Minnesota/North Dakota/South Dakota

INSTRUCTIONS

IMPORTANT – PLEASE READ BEFORE COMPLETING

Please read your enrollment form thoroughly. If the following items are not completed, the processing of your enrollment form will be delayed.

1. Employer name.
 2. Date of employment.
 3. Social Security number.
 4. Name, full address and telephone number.
 5. Date of birth for you and all eligible dependents.
 6. If enrolling in Medica Elect® or Medica EssentialSM or Medica FocusSM you must complete your Clinic Name and Clinic Number selection.
 7. Signature of employee and date signed.
 8. Other insurance information.
- You are not required to disclose the performance of, or results of a test to determine the presence of the human immunodeficiency virus (HIV) antibody or other bloodborne pathogen* performed on (1) a criminal offender or crime victim as a result of a crime that was reported to the police; (2) a patient who received the services of emergency medical services personnel* at a hospital or medical care facility; or (3) emergency medical services personnel who were tested as a result of performing emergency medical services.
 - If **waiving medical coverage**, complete Sections A and D only.

DEFINED TERMS: The term “emergency medical services personnel” includes (1) individuals employed or receiving compensation to provide out-of-hospital emergency medical services such as a firefighter, paramedic, emergency medical technician, licensed nurse, rescue squad person, or other individual who serves as an employee or volunteer of an ambulance service as defined by Minnesota law or a member of an organized first responder squad that is formally recognized by a political subdivision in the state, who provides out-of-hospital emergency medical services during the performance of the individual’s duties; (2) an individual employed as a licensed peace officer under Minnesota law; (3) an individual employed as a crime laboratory worker while working outside the laboratory and involved in a criminal investigation; (4) any individual who renders emergency care or assistance at the scene of an emergency or while an injured person is being transported to receive medical care and who is acting as a good samaritan as described under Minnesota law; and (5) any individual who, in the process of executing a citizen’s arrest as defined by Minnesota law, may have experienced a significant exposure to a source individual*.

The term “bloodborne pathogen” means pathogenic microorganisms that are present in human blood and can cause disease in humans. These pathogens include, but are not limited to, hepatitis B virus (HBV), hepatitis C virus (HCV) and human immunodeficiency virus (HIV).

The term “source individual” means an individual, living or dead, whose blood tissue or potentially infectious body fluids may be a source of bloodborne pathogen exposure to an emergency medical services personnel. Examples include, but are not limited to, a victim of an accident, injury, or illness, or a deceased person.

The term “significant exposure” means contact likely to transmit a bloodborne pathogen, in a manner supported by the most current guidelines and recommendations of the United States Public Health Service at the time an evaluation takes place, that includes (1) percutaneous injury, contact of mucous membrane or nonintact skin, or prolonged contact of intact skin; and (2) contact, in a manner that may transmit a bloodborne pathogen, with blood, tissue, or potentially infectious body fluids.

Large Group Enrollment Form Minnesota/North Dakota/South Dakota



PLEASE TYPE or PRINT PRESS FIRMLY.

A. EMPLOYEE INFORMATION – This entire section must be completed even if you or your dependents DO NOT want coverage.

Employee's Social Security Number		Employer Name			Hire Date (Required)	
Employee's First Name	MI	Last Name		Clinic Name and Clinic Number		
Employee's Home Address — Street		City	County	State	Zip Code	Occupation/Job Title
Home Telephone		Work Telephone & Extension		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> Married	Date of Birth (Month/Day/Year)

Do you or any of your dependents speak a language other than English as your primary language? Yes No

If yes, please list name and language _____

B. DEPENDENT INFORMATION – List all family members to be covered, write name(s) as it should appear on I.D. card. Use extra paper if necessary.

- If currently enrolled and adding dependents, complete your information in Section A and dependent information in Section B.
- If dependent's address is different than employee's address, attach dependent's name and full address to this form.
- If terminating a dependent, please complete the *Change Termination Form*.

Name/Social Security Number First M.I. Last	Relationship	Sex	Birth Date Month/Day/Year	Full-time Student* (Age 19+)	Clinic Name and Clinic Number
1) Social Security Number:		M F		<input type="checkbox"/> Yes <input type="checkbox"/> No School Name: _____	Clinic Name: _____ Clinic Number: _____
2) Social Security Number:		M F		<input type="checkbox"/> Yes <input type="checkbox"/> No School Name: _____	Clinic Name: _____ Clinic Number: _____
3) Social Security Number:		M F		<input type="checkbox"/> Yes <input type="checkbox"/> No School Name: _____	Clinic Name: _____ Clinic Number: _____
4) Social Security Number:		M F		<input type="checkbox"/> Yes <input type="checkbox"/> No School Name: _____	Clinic Name: _____ Clinic Number: _____
5) Social Security Number:		M F		<input type="checkbox"/> Yes <input type="checkbox"/> No School Name: _____	Clinic Name: _____ Clinic Number: _____

Separate for faxes only

* This field is not required by Medica. Medica does not administer student status verification, however your employer may request this information for their records.

C. COVERAGE AND BENEFIT OPTIONS – Please check all that apply.

- Medical Benefit Selection Plan Name: _____
Medical Coverage Level: Employee Only Employee + Spouse Employee + Child(ren) Employee + Family
- Medica Direct® Selection
 Health Reimbursement Arrangement (HRA) Flexible Spending Account (FSA)
 I certify that I am eligible to participate in a Health Savings Account, then choose: Health Savings Account (HSA)
- Dental – Administered and Underwritten by Delta Dental (if checked complete dental coverage level information)
Dental Coverage Level: Employee Only Employee + Spouse Employee + Child(ren) Employee + Family
- Life AD&D (if checked complete beneficiary and relationship information)
 Name of Beneficiary: _____ Relationship to Employee: _____
- Dependent Life

D. WAIVER OF MEDICAL COVERAGE – This entire section must be completed if you or your dependents DO NOT want coverage.

- I understand that I am eligible for coverage through my employer. I DO NOT want coverage for:
 Me and my dependents My dependents only My spouse
- The reason I am declining coverage at this time is because I or my dependents have coverage provided through:
 Spouse's group plan Individual Policy MCHA (Dates of coverage) _____
 Medicare Group Coverage Continuation (COBRA) South Dakota Risk Pool (Dates of coverage) _____
 MinnesotaCare Medical Assistance CHAND (Dates of coverage) _____
 Other _____

Date Signed _____ / _____ / _____ Employee's Signature _____

Please take a moment to read the following information, which may affect your or your dependents' enrollment rights.

Your Special Enrollment Rights Under HIPAA

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, adoption, or placement for adoption.

You may have additional enrollment rights under applicable state law. To obtain more information or request special enrollment, contact Medica Customer Service at 952-945-8000 or 1-800-952-3455. TTY calls should be directed to 952-992-3190 or 1-800-841-6753.

MEDICA[®]

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