

COBRA/Group Coverage Continuation Enrollment Form

A. EMPLOYEE INFORMATION (this section must be completed)

First Name	M.I. Last Name	Birth Date / /	Social Security Number
Medica Member ID Number 		Home Telephone	Work Telephone

LIST ONLY THOSE MEMBERS ENROLLING IN CONTINUATION (please do not list employee again, if not enrolling):

#	Member Name(s)	Relationship	Social Security Number(s)
1.		Employee	
2.		Spouse	
3.		Dependent	
4.		Dependent	

THE FOLLOWING QUALIFYING EVENT(S) OCCURRED ON: Date / /

- Death of the covered **EMPLOYEE**
- Termination (for other than gross misconduct), lay-off or reduction of hours of employment of the covered **EMPLOYEE**
- Divorce or legal separation from covered **EMPLOYEE**
- Enrollment of the **EMPLOYEE** for Medicare benefits
- A **DEPENDENT** child ceasing to be an eligible dependent under the requirements of the plan
- A **RETIREE** losing coverage within one year before or after the employer files bankruptcy under Title XI, United States Code
- Uniformed Services Employment & Reemployment Rights Act (USERRA) – **EMPLOYEEES** who are called to military duty in the uniformed services

COVERAGE DESIGNATION:	IF YOU CURRENTLY HAVE DENTAL COVERAGE, CHECK BELOW IF YOU WISH TO CONTINUE:	IF YOU CURRENTLY HAVE FSA COVERAGE, CHECK BELOW IF YOU WISH TO CONTINUE:
<input type="checkbox"/> Family Medical Coverage <input type="checkbox"/> Single Medical Coverage	<input type="checkbox"/> Family Dental Coverage <input type="checkbox"/> Single Dental Coverage	<input type="checkbox"/> Flexible Spending Account (FSA)

B. EMPLOYEE AUTHORIZATION AND REPRESENTATION

Read this section, date and sign the form.

On behalf of myself and anyone enrolled on or added to this form ("Us"), I authorize any hospital, clinic, institution, physician, insurance company, employer or other person to give Medica or any of its designees any and all records or information pertaining to medical history or services rendered to Us. I understand that this information will be used for underwriting, risk rating, enrollment or eligibility for benefits. I understand that in certain circumstances Medica may disclose the information collected to third parties without authorization and that the individuals enrolled on or added to this form have the right to see and correct their personal information in accordance with applicable law. I understand that I have the right to review Medica's Privacy Notice before signing this form and to request a copy at any time. I authorize on behalf of Us the use of a Social Security Number for the purpose of identification. The information provided on this form is accurate and complete, to the best of my knowledge and/or belief. I understand and agree that any omissions or incorrect statements knowingly made by Us on this form may invalidate my or my dependent's coverage. I understand that I may revoke this authorization by notifying Medica in writing. If I revoke the authorization, it will not affect any actions already taken by Medica prior to Medica's receipt of the revocation. If I refuse to sign this authorization, it will affect my dependents' and my eligibility and enrollment for benefits. I understand that I may request a copy of this completed authorization form. Information used or disclosed pursuant to this authorization will remain subject to Medica's privacy standards.

For North Dakota and South Dakota residents: For purposes of facilitating enrollment, unless revoked, this authorization permits Medica to obtain information about Us for 24 months from the date of signature.

For Minnesota residents: For purposes of facilitating enrollment, unless revoked, this authorization permits Medica to obtain information about Us from the date of signature until termination of our coverage.

This authorization does not extend to a release concerning the performance of, or results of, a test to determine the presence of the 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.

This coverage does not provide benefits for a condition for which medical advice, diagnosis, care, or treatment (including treatment with prescription drugs) was recommended or received during the 6 months immediately preceding the enrollment date, until the coverage has been active for at least 12 consecutive months, or for late entrants, 18 consecutive months. Credit will be given for prior creditable coverage to reduce the pre-existing condition limitation period.

For Wisconsin residents: For purposes of facilitating enrollment, unless revoked, this authorization permits Medica to obtain information about Us for 30 months from the date of signature.

Employee Signature: X Date Signed: _____

I understand that providing false information or omission of relevant information in this form may result in the denial of claims or cancellation or rescission of coverage.

TO BE COMPLETED BY EMPLOYER

Full Company Name	Branch/Division	Group Number	Please fax completed form to: 248-733-6064 or mail to: Medica PO Box 30986 Salt Lake City, UT 84130-0986
Group Administrator Signature	Employer's Phone No.	Date / /	