Minnesota/North Dakota/South Dakota/Wisconsin

Custom Options by Medica®
Selection Change Form

MEDICA®

Employer or Group Administrator, please fax forms to: **248-733-6064**
or send to: **Medica, PO Box 30986, Salt Lake City, UT 84130-0986**

Employer Name (please print): _____

Employee Name
(First, MI, Last): _____ Social Security Number: _____

Please identify your coverage level designation for the eligible product offerings with this renewal election:

Medical Benefits	**Flexible Spending Account (FSA)**
for: ❑ Employee ❑ Spouse ❑ Child(ren) ❑ All family members	❑ Add* ❑ Continue* ❑ Terminate * If you select either "Add" or "Continue" for your FSA election at renewal, you will need to complete a new FSA election form. FSA elections do not carry over year to year.

Please check benefit selection and fill in Plan Design Number in the space provided below.

❑ Medica Choice®	Plan Design No.:	❑ MIC	Plan Design No.:
❑ Medica Elect®*	Plan Design No.:	❑ Passport from Medica℠	Plan Design No.:
❑ Medica Essential℠*	Plan Design No.:	❑ Patient Choice Insights℠ by Medica	Plan Design No.:
❑ Medica Focus℠*	Plan Design No.:		

*** Please provide clinic information if enrolling in Medica Elect, Medica Essential or Medica Focus.**

Name	Relationship	Care Clinic Name	Clinic Number
	Employee		
	Spouse		
	Dependent		
	Dependent		
	Dependent		

Care Clinic selections can be changed once per month. All changes received by the 20th of the month will take effect on the 1st of the following month. Please contact Medica Customer Service at 952-945-8000 or 1-800-952-3455 to make future Care Clinic changes.

Note:
- All new enrollees must complete a Group Employee Enrollment Form.
- All existing active members will be rolled into the new group plan designated.
- I understand and agree that I will not be able to change my benefit plan selection noted above until next year's renewal unless a qualified special enrollment has occurred.

EMPLOYEE AUTHORIZATION & REPRESENTATION – Read this section, date and sign the application.

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 render 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:** _____

For Employer Use Only

Group Number – Current Plan: _____ Effective Date of Change: _____

Group Number – New Plan: _____ Signature: _____

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