

# LARGE GROUP ENROLLMENT FORM

## Wisconsin

### 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. Full name.
  2. Date of hire.
  3. Full address.
  4. Social Security number.
  5. Date of birth for you and all eligible dependents.
  6. Other insurance information.
  7. Signature of employee and date signed.
- If **waiving medical coverage**, complete Sections A and D only.

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

\* 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.**

- 1)  Medical Benefit Selection Plan Name: \_\_\_\_\_  
**Medical Coverage Level:**  Employee Only     Employee + Spouse     Employee + Child(ren)     Employee + Family
- 2) 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)
- 3)  Life AD&D (if checked complete beneficiary and relationship information)  
Name of Beneficiary: \_\_\_\_\_ Relationship to Employee: \_\_\_\_\_
- 4)  Dependent Life

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

- 1) 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
- 2) The reason I am declining coverage at this time is because I or my dependents have coverage provided through:  
 Spouse's group plan     Medicare     Group Coverage Continuation (COBRA)     Individual Policy  
 Medical Assistance     Other \_\_\_\_\_

Date Signed \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_      Employee's Signature \_\_\_\_\_

Separate for faxes only

**E. CURRENT & PREVIOUS COVERAGE – Failure to fully complete this section may result in a pre-existing condition limitation.**

**Important Note:** 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.

- 1) Do you, or any family member listed on this form, have current health coverage or had previous health coverage within the last 24 months? . . . . .  Yes  No  
 If “Yes,” you must fully complete the following section. Starting with the employee, list each family member applying for coverage and include information for all previous coverage in effect during the last 24 months.

Date of Coverage (last 24 months)	Name of Insurance Company	Names of All Family Members Covered (use extra paper if necessary)
Start: ____ / ____ / ____ End: ____ / ____ / ____		
Start: ____ / ____ / ____ End: ____ / ____ / ____		
Start: ____ / ____ / ____ End: ____ / ____ / ____		
Start: ____ / ____ / ____ End: ____ / ____ / ____		
Start: ____ / ____ / ____ End: ____ / ____ / ____		

- 2) Have you been a Medica member before? . . . . .  Yes  No  
 3) On the day your Medica coverage begins, will any family members be covered by any other health insurance or Medicare? . . . . .  Yes  No  
 4) Are you or your spouse covered by Medicare?  Part A or  Part B Please attach copy of Medicare card or give effective dates.  
 5) Medicare eligibility due to:  Age  Kidney failure  Disability Name of condition(s) \_\_\_\_\_

**F. EMPLOYEE AUTHORIZATION & 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 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. I understand that I may request a copy of this completed authorization form. If I refuse to sign this authorization, it will affect my dependents’ and my eligibility and enrollment for benefits. Information used or disclosed pursuant to this authorization will remain subject to Medica’s privacy standards.

**Wisconsin 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.

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.*

**G. FOR EMPLOYER USE ONLY**

- 1) To add dependents and employee, if applicable (write date of event in space provided):  
 Marriage \_\_\_\_\_  Court Order (attached copy) \_\_\_\_\_  Birth/Adoption/Placement for Adoption \_\_\_\_\_
- 2) To add employee and/or dependents because of termination of other coverage:  
 Employee and/or dependent had health insurance coverage when coverage under employer’s plan was offered previously. Medica will require additional information in order to determine whether you may make such additions.

Full Company Name		Division/Department #		Group #	
Employee I.D. #	Hire Date (Required) / /	Effective Date / /	<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Status Change _____ (date)	
			<input type="checkbox"/> Special Enrollment	<input type="checkbox"/> Return from layoff/leave on _____ (date)	
			<input type="checkbox"/> New Hire		
<input type="checkbox"/> Full Time	<input type="checkbox"/> Union	<input type="checkbox"/> Salaried	Approved By (Signature)		Date
<input type="checkbox"/> Part Time	<input type="checkbox"/> Non-Union	<input type="checkbox"/> Hourly	<u>  X  </u>		

Employer should send all completed forms to: Medica  
 PO Box 30986  
 Salt Lake City, UT 84130-0986

*A person who submits a form or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.*

**MEDICA®**

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