



**E. Current & Previous Coverage**

Failure to fully complete this section may result in a Coordination of Benefits inquiry and/or a pre-existing condition limitation if applicable per your group contract.

**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. If your coverage is still in effect, please write "current" or "present" in the end date field.

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: ___/___/___		

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, your spouse or any dependents covered by Medicare?  Yes  No  
If "Yes," please attach a copy of each Medicare ID card and complete the following:

**Employee Medicare Information:**

**Part A:**  Enrolled (Effective Date: \_\_\_/\_\_\_/\_\_\_)  Ineligible\* for Part A  Not enrolled in Part A (chose not to enroll)  
**Part B:**  Enrolled (Effective Date: \_\_\_/\_\_\_/\_\_\_)  Ineligible\* for Part B  Not enrolled in Part B (chose not to enroll)  
**Part D:**  Enrolled (Effective Date: \_\_\_/\_\_\_/\_\_\_)  Ineligible\* for Part D  Not enrolled in Part D (chose not to enroll)  
**Reason for Medicare eligibility:**  Over age 65  Kidney disease  Disabled  Disabled but actively at work

**Spouse/Dependent Medicare Information: Name:** \_\_\_\_\_

**Part A:**  Enrolled (Effective Date: \_\_\_/\_\_\_/\_\_\_)  Ineligible\* for Part A  Not enrolled in Part A (chose not to enroll)  
**Part B:**  Enrolled (Effective Date: \_\_\_/\_\_\_/\_\_\_)  Ineligible\* for Part B  Not enrolled in Part B (chose not to enroll)  
**Part D:**  Enrolled (Effective Date: \_\_\_/\_\_\_/\_\_\_)  Ineligible\* for Part D  Not enrolled in Part D (chose not to enroll)  
**Reason for Medicare eligibility:**  Over age 65  Kidney disease  Disabled  Disabled but actively at work

\* Only check "Ineligible" if you have received documentation from your Social Security benefits that indicate that you are not eligible for Medicare.

**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 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: \_\_\_\_\_

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.



**IMPORTANT – PLEASE READ BEFORE COMPLETING.**

Please read your enrollment/change/cancellation form thoroughly. If the following items are not completed, the processing of this form may be delayed.

1. Company 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 Medica Elect® or Medica Essential,<sup>SM</sup> you must complete your Clinic Name and Clinic Number selection.
7. Signature of employee and date signed.
8. Current and previous coverage information.

■ If **waiving medical coverage**, complete Sections A and D only.

■ For new enrollees, please submit this completed enrollment/change/cancellation form to your employer.

■ If you are currently enrolled and are only **adding a dependent** to your existing contract, please include your name in Section A and your dependent's information in all other sections.

**Employers should send all completed forms to:**

Medica  
PO Box 30772  
Salt Lake City, UT 84130-0772

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