Key Account Minnesota/North Dakota/South Dakota/Wisconsin

MEDICA®

Custom Options by Medica® Renewal Medical Benefit Election Form

Use this form at renewal to change benefit plan selection. All new enrollees must complete a Medica Enrollment/Change/Cancellation Form.

A. EMPLOYEE INFORMATION

First Name	M.I.	Last Name	Social Security Number

B. RENEWAL MEDICAL BENEFIT ELECTION

❑ Enroll all existing active family members into the new Medical plan designation identified below

❑ Medical plan*, please write your medical plan selection here:____________________

*Please complete Section C if electing Medica Elect® or Medica Essential℠

C. CARE CLINIC DESIGNATION – Required for Medica Elect and Medica Essential elections only.

A Care Clinic designation must be identified for all existing active family members (attach additional sheet if necessary):

	Relationship	First Name	M.I.	Last Name	Clinic Name	Clinic Number
1	Employee					
2	Spouse					
3	Dependent					
4	Dependent					
5	Dependent					

Note: Future Care Clinic changes can be done once per month. All future changes received by the 20th of the month will take effect on the 1st of the following month. Please call one of our Customer Care Professionals at the number on the back of the patient's ID card to make future Care Clinic changes.

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.

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 Signature: X____________________ **Date Signed:** __________

For Employer Use Only

Approved by (Signature): ____________________

Employer Name: ________________ Effective Date of Change: ________________

Current Policy Number: ________________ Current Plan Variation/Reporting Code: ______/______

New Policy Number: ________________ New Plan Variation/Reporting Code: ______/______

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Employer or Group Administrator, please fax forms to: **248-733-6075**
or send to: **Medica, PO Box 30772, Salt Lake City, UT 84130-0772**