

Minnesota/North Dakota/South Dakota/Wisconsin

## Assistance Eligible Individual (AEI) Status Request & Continuation Enrollment Form

This form is for use by individuals who have experienced an involuntary termination of employment and are applying for continuation coverage. Please read the important information about your rights included in the "Summary of the Continuation Coverage Premium Reduction Provisions Under ARRA, as Amended." This summary was included in the Notice you received concerning your rights under ARRA. To apply for ARRA Premium Reduction, complete this form and return it to the employer.

### Section A. Continuation Election Employee & Family 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 list the employee again, if enrolling.)

	Member Name (s)	Relationship to employee: (spouse, domestic partner, child, grandchild)	Social Security Number 
1.		Employee	
2.			
3.			
4.			
5.			

### Section B. Request for Treatment as an Assistance Eligible Individual

Employee Information (list any dependents applying for premium assistance below)	
<b>To qualify, none of your answers below can be "No"</b>	
1. The loss of employment was involuntary.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. The loss of employment occurred at some point on or after September 1, 2008 and on or before May 31, 2010.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. If the loss of employment was preceded by a qualifying event that was a reduction of hours, the reduction of hours took place at some point on or after September 1, 2008 and on or before May 31, 2010 AND the loss of employment occurred on or after March 2, 2010.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
4. I elected (or am electing) continuation coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. I am NOT eligible for other group health plan coverage (or I was not eligible for other group health plan coverage during the period for which I am claiming a reduced premium).	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. I am NOT eligible for Medicare (or I was not eligible for Medicare during the period for which I am claiming a reduced premium).	<input type="checkbox"/> Yes <input type="checkbox"/> No

### Dependent Information (note: only spouses & dependent children can qualify as an AEI. Individuals such as domestic partners and grandchildren will not qualify.)

Dependent Name	Relationship to Employee	I elected continuation coverage. <input type="checkbox"/> Yes <input type="checkbox"/> No	I am NOT eligible for other group health plan coverage. <input type="checkbox"/> Yes <input type="checkbox"/> No	I am NOT eligible for Medicare <input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct. If I become eligible for other group health plan coverage or Medicare, I will notify my employer.

Employee Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Type or Print Name: \_\_\_\_\_

**Section C. Employee Authorization and Representation to Continue Coverage**

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 \_\_\_\_\_

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

**Section D. Employer Attestation**

**FOR EMPLOYER USE ONLY –must be completed**  
**AEI Status Request & Continuation Enrollment Form**

This application is: (check box)  Approved  Denied  Approved for some/denied for others (explain in #5 below)

If approved, for all or some applicants, specify the date of involuntary termination (as defined in the IRS Notice 2009-27) of employment AND if applicable, the date of any preceding reduction in hours that resulted in loss of coverage:

If approved, for all or some applicants, specify amount employer will contribute towards the continuation premium, if any. (If zero, please indicate. Do not leave blank).

Were all or some applicants receiving the subsidy through a previous health insurance carrier or employer? Yes or No  
 If yes, specify effective date the subsidy began with previous carrier or employer and which applicants were receiving the subsidy.

If denied, for all or some applicants, specify reason(s) below.

Upon completion, provide a copy of this form to the applicant and to Medica. Retain a copy for your files.

REASON FOR DENIAL OF TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL		
1. Loss of employment was voluntary.		<input type="checkbox"/>
2. The involuntary loss did not occur on or after September 1, 2008 and on or before May 31, 2010.		<input type="checkbox"/>
3. The qualifying event was a reduction of hours and was not followed by a termination of employment (or the termination occurred prior to March 2, 2010 or after May 31, 2010).		<input type="checkbox"/>
4. Individual did not appropriately elect continuation coverage.		<input type="checkbox"/>
5. Other (please explain)		<input type="checkbox"/>
Full Company Name	Branch/Division	Group Number
Group Administrator Signature	Employer's Phone No.	Date / /

Please mail to:  
 Medica Enrollment  
 MN015-2838  
 4316 Rice Lake Road  
 Duluth, MN 55811