Minnesota/North Dakota/South Dakota/Wisconsin

MEDICA®

Small Group Enrollment/Change/Cancellation Form

Please type or print clearly. See back page for instructions.

Group Number:

A. EMPLOYEE INFORMATION

❑ Enroll ❑ Cancel ❑ Change	First name / M.I. / Last name	Social Security Number	Marital Status ❑ Single ❑ Married
	Street address / Apt. # / City	County / State / Zip Code	

Home telephone	Work/Cellular telephone	Occupation/job title: Owner/officer? ❑ Yes ❑ No	How many hours do you work per week?

Sex ❑ M ❑ F	Birth date	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:

Clinic name	Clinic number	Have you been a Medica member before? ❑ Yes ❑ No

B. DEPENDENT INFORMATION

List all members to be covered. Write name as it should appear on the I.D. card.

	Check appropriate box	First name M.I. Last name / Dependent's Social Security Number	Sex	Birth date (mm/dd/yy)	Relationship*	Full-time student?**	Please provide clinic information if enrolling in Medica Elect,® Medica Essential[SM] or Medica Focus.[SM]
1	❑ Enroll ❑ Cancel ❑ Change	SS#	❑ M ❑ F			❑ Yes ❑ No	Clinic name: Clinic number:
2	❑ Enroll ❑ Cancel ❑ Change	SS#	❑ M ❑ F			❑ Yes ❑ No	Clinic name: Clinic number:
3	❑ Enroll ❑ Cancel ❑ Change	SS#	❑ M ❑ F			❑ Yes ❑ No	Clinic name: Clinic number:
4	❑ Enroll ❑ Cancel ❑ Change	SS#	❑ M ❑ F			❑ Yes ❑ No	Clinic name: Clinic number:

Important: * For court-ordered dependent(s), legal documentation must be attached.

** This is not required by Medica. Medica does not administer student status verification, however, your employer may request this information for their records.

C. PRODUCT SELECTION

Please check all that apply. Benefit offerings are dependent upon employer selection.

1) ❑ Medical Benefit 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)

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 spouse ❑ My dependents only

2) The reason I am declining coverage at this time is because I or my dependents have coverage provided through:
❑ Spouse's group plan ❑ Individual Policy ❑ MCHA (dates of coverage): ______
❑ Medicare ❑ Group Coverage Continuation (COBRA) ❑ South Dakota Risk Pool (dates of coverage): ______
❑ MinnesotaCare ❑ Medical Assistance ❑ CHAND (dates of coverage): ______
❑ Other: ______

3) I understand that if I decide to apply for coverage at a later date, I and/or my dependents may be required to submit additional health information (at my own expense) and that a pre-existing condition exclusion may apply.

Employee Signature: X ______ Date Signed: ______

(only sign if you are waiving coverage)

E. CURRENT & PREVIOUS COVERAGE

Failure to complete this section may result in a pre-existing condition limitation. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition.

1) Do you, or any family member listed on this form, have current health coverage or have you, or any family member listed on this form, had previous health coverage in effect during 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 members covered (use extra paper if necessary)
Start: End:		
Start: End:		
Start: End:		

F. COORDINATION OF BENEFITS

Failure to complete this section may result in a delay in the processing of your claims.

1) On the day your Medica coverage begins, will you or any family members listed have dual health insurance or Medical coverage? . . . . ❑ Yes ❑ No

G. MEDICARE INFORMATION

1) 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: _____ /_____ /_____)
Part B: ❑ Enrolled (Effective Date: _____ /_____ /_____)
Part D: ❑ Enrolled (Effective Date: _____ /_____ /_____)

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: _____ /_____ /_____)
Part B: ❑ Enrolled (Effective Date: _____ /_____ /_____)
Part D: ❑ Enrolled (Effective Date: _____ /_____ /_____)

Reason for Medicare eligibility:
❑ Over age 65 ❑ Kidney disease ❑ Disabled
❑ Disabled but actively at work

H. 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 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.

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.

I. TO BE COMPLETED BY EMPLOYER

ATTENTION EMPLOYER REPRESENTATIVE: To ensure accurate processing of application, please
1) Review all sections and confirm employee completed the appropriate information.
2) Complete Section I1 and Section I2 a, b or c based on type of transaction.
3) Provide approval and signature in Section I3.

I1. GROUP INFORMATION:

Employer Name	Group Number
❑ Active ❑ Retired Date:	

I2. QUALIFYING EVENT:

a. NEW ENROLLMENT/ADDITIONS

Date of Hire:	Requested Effective Date:
______/______/______	______/______/______

(check one):

❑ New hire
❑ Special enrollment
  ❑ Marriage
  ❑ Birth
  ❑ Court-ordered dependent (attach documentation)
  ❑ Adoption/placement for adoption (attach documentation)
❑ Late entrant
❑ Other (describe):

____

b. CHANGES

Date of Hire:	Requested Effective Date:
______/______/______	______/______/______

(check one):

❑ Status change
❑ Plan change
❑ Return from leave/layoff
❑ Address change
❑ Other (describe):

COBRA/CONTINUATION

Start Date:	End Date:
______/______/______	______/______/______

Qualifying event: ____________________________________

If COBRA/Continuation due to divorce, identify relationship to employee:

Employee name: ____________________________________

Employee SSN:____________________________________

c. CANCELLATIONS

(check one)

❑ Cancel all coverage
❑ Cancel dependents listed in Section B

Last date of employment:
_____/_____/_____

Requested effective date of cancellation:
_____/_____/_____

Reason: (check one)

❑ Employee terminated
❑ Moved out of service area
❑ Dependent reached student/dependent maximum age
❑ Divorce
❑ Death
❑ Other (describe):

I3. APPROVAL AND SIGNATURE:

Approved by (Signature): X____ Date Signed:______________________

Print name:	Position:	Telephone:

INSTRUCTIONS

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. Employer name.
2. Date of employment.
3. Social Security Number.
4. Name, full address and phone number.
5. Date of birth for you and all eligible dependents.
6. If enrolling in Medica Elect,® Medica Essential℠ or Medica Focus℠ you must complete your Clinic Name and Clinic Number selection.
7. Signature of employee and date signed.
8. Details to all health questions checked yes.
9. Other insurance information.

- If **waiving medical coverage,** complete Sections A and D.
- 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 30986, Salt Lake City, UT 84130-0986

BROKER NOTE: This form may NOT be utilized when submitting employer group proposal for new business with Medica. This form may only be utilized after initial new group set up has been completed.

Your Special Enrollment Rights Under HIPAA

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, adoption, or placement for adoption.

You may have additional enrollment rights under applicable state law. To obtain more information or request special enrollment, contact Medica Customer Service at 952-945-8000 or 1-800-952-3455. TTY calls should be directed to 952-992-3190 or 1-800-841-6753.

What You Need to Know About Pre-existing Condition Limitations

This plan imposes a pre-existing condition limitation. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This limitation applies only to conditions for which medical advice, diagnosis, care, or treatment (including taking prescription drugs) was recommended or received within a six-month period. Generally, this six-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the six-month period ends on the day before the waiting period begins. The pre-existing condition limitation does not apply to pregnancy nor to a child who is enrolled in the plan or who has other creditable coverage within 30 days after birth, adoption, or placement for adoption, unless the child subsequently has a break in coverage of 63 days or more.

This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

If you have further questions about the pre-existing condition limitation or your creditable coverage, please contact Medica Customer Service at Mail Route CP555, P.O. Box 9310, Minneapolis, MN 55440-9310, or call the number listed on the back of your ID card. TTY users can call 952-992-3190 or 1-800-841-6753.

Visit us on the Internet at www.medica.com.

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