Minnesota/North Dakota/South Dakota/Wisconsin

MEDICA.

Group Enrollment/Change/Cancellation Form

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

Group Number:

A. EMPLOYEE INFORMATION

If changing name or address, please enter new information.

Have you been a Medica member before?. . . ❑ Yes ❑ No

❑ Enroll
❑ Cancel
❑ Change

First name (Legal Name)[4] M.I.[4] Last name[4]

Social Security Number[1]

Marital Status ❑Single ❑Married

Street address Apt. # City County State Zip Code

Email Address

Home telephone

Work/cellular telephone

Sex ❑M ❑F

Birth date (mm/dd/yy)

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:

Primary Care Clinic (Required for Medica Elect,® Medica Essential℠)

Primary Care Clinic identification (PCC ID) number

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[4] M.I.[4] Last name[4] / Dependent's SSN[1]	Sex	Birth date (mm/dd/yy)	Relationship[2]	Full-time student?[3]	Required for Medica Elect, Medica Essential
1	❑ Enroll ❑ Cancel ❑ Change	SS#	❑M ❑F			❑Yes ❑No	PCC name: / PCC ID:
2	❑ Enroll ❑ Cancel ❑ Change	SS#	❑M ❑F			❑ Yes ❑ No	PCC name: / PCC ID:
3	❑ Enroll ❑ Cancel ❑ Change	SS#	❑M ❑F			❑ Yes ❑ No	PCC name: / PCC ID:
4	❑ Enroll ❑ Cancel ❑ Change	SS#	❑M ❑F			❑ Yes ❑ No	PCC name: / PCC ID:

Important:
1. Your Social Security number (SSN) is requested to report your coverage status to the federal government. The IRS requires Medica to report this information. If you choose not to provide your SSN, you will likely be contacted by the IRS, and/or Medica asking you to verify your SSN for 1095 tax form purposes.
2. For court-ordered or adopted dependent(s), legal documentation must be attached.
3. Medica does not administer student status verification, however, your employer may request this information for their records.
4. Please provide each applicants name as stated on their Social Security card, if they have a Social Security card.

C. PRODUCT SELECTION

❑ Medical Plan

If your employer offers you a choice of medical plans, please write your medical plan selection here:

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 ❑ South Dakota Risk Pool (dates of coverage): _____
❑ Medicare ❑ Group Coverage Continuation (COBRA) ❑ CHAND (dates of coverage): _____
❑ MinnesotaCare ❑ Medical Assistance ❑ Other: _____

Employee Signature: X _____ Date Signed: _____

(only sign if you are waiving coverage)

E. COORDINATION OF BENEFITS

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

1) While you are covered under this policy, will you or any family members covered under this plan have other health insurance or medical coverage . . . . . ❑ 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.
If your coverage is still in effect, please write "current" or "present" in the end date field.

Date of Coverage		Name of Insurance Company	Names of all members covered (use extra paper if necessary)
Start:	End:		
Start:	End:		
Start:	End:		
Start:	End:		

F. 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

G. 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.

I understand that this plan does not include coverage for the pediatric dental essential health benefit and coverage for these services can be purchased through a separate pediatric dental plan through Delta Dental®.

I understand that providing false information or omission of relevant information in this form may result in the denial of claims or cancellation or retroactive termination of coverage.

(!) Employee Signature: X_____ Date Signed: _____

H. 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 1 and Section 2 a, b, c or d based on type of transaction.
3) Provide approval and signature in Section 3.

1) GROUP INFORMATION:

Employer Name	Group Number
❑ Active ❑ COBRA ❑ Retired Date:	Department Number

2) ENROLLMENT ACTION REQUESTED:

a. NEW ENROLLMENT/ADDITIONS

Date of Hire: (required) ____/____/____ | Requested Effective Date: ____/____/____

(check one):

- ❑ New group
- ❑ Open Enrollment
- ❑ New hire
- ❑ Special enrollment
  - ❑ Marriage ____/____/____
  - ❑ Birth
  - ❑ Court-ordered dependent (attach documentation)
  - ❑ Adoption/placement for adoption (attach documentation)
  - ❑ Loss of coverage ____/____/____
  - ❑ Loss of SCHIP/Medicaid *____/____/____
    (*Loss of coverage end date)
  - ❑ SCHIP/Medicaid Premium Assistance **____/____/____
    (**Date eligibile for premium assistance)
- ❑ Late entrant (Large group only)
- ❑ Trade Act of 2009 ____/____/____
- ❑ Other (describe): _____

b. CHANGES

Date of Hire: (required) ____/____/____ | Requested Effective Date: ____/____/____

(check one):

- ❑ Name change
- ❑ Plan change
- ❑ Return from leave/layoff
- ❑ Address change
- ❑ Status change (PT/FT) ____/____/____
- ❑ Other (describe): _____

c. COBRA/CONTINUATION

Start Date: ____/____/____

Qualifying Event: _____

Trade Act Eligible: ❑ Yes ❑ No

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

Employee Name: _____

Employee SSN: _____

d. 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
- ❑ Other (describe): _____
- ❑ Medicare Eligible
- ❑ COBRA termination
- ❑ Divorce
- ❑ Death

3) EMPLOYER APPROVAL AND SIGNATURE:

Approved by (Signature): X _____ Date Signed: _____

Print name: Position: Telephone:

Employer should send all completed forms to: Medica, PO Box 30986, Salt Lake City, UT, 84130-0986 **or fax to:** 1-248-733-6064

THIS PAGE TO BE COMPLETED BY EMPLOYER - RETURN ALL PAGES TO MEDICA

PO Box 9310
Minneapolis, MN 55440-9310

MEDICA®

Accountable Care Organization (ACO) Consent

Help Us Improve Your Health Care Experience

One of the unique features of the ACO plan is how Medica works with your provider to coordinate your health care. Medica and your care system can enhance this experience by sharing member information with each other, ensuring that you're offered programs and services that can benefit you. To share your health information (including treatment from providers outside your care system), we need your permission. Please complete the form below.

Request for Permission to Share Your Information

I authorize the release of my health record information (and that of my dependents age 11 and under) between Medica and the care systems for care coordination purposes.

☐ **Yes** ☐ **No**

ACO Product name: _____

Employer name: _____

Subscriber's Information
The subscriber is the person enrolled in the plan through his or her employer.

Subscriber's name (First and Last) *please print*: _____

Subscriber's date of birth: _____

Subscriber's email address: _____

Subscriber's signature: _____

Date: _____
(Your consent is valid for one year from the date you sign this form)

If you have family members age 12 or older who are also covered by your plan, please have them complete the information on the back of this form.

Continued on reverse

Medica® is a registered service mark of Medica Health Plans. "Medica" refers to the family of health plan businesses that includes Medica Health Plans, Medica Health Plans of Wisconsin, Medica Insurance Company, Medica Self-Insured and Medica Health Management, LLC.

An Equal Opportunity Employer

Dependents' Information

Dependents age 12 and older must provide their own consent by signing below. If you need additional space, please use another piece of paper to provide the requested information for each dependent.

Dependent #1

I authorize the release of my health record information ____ Yes ____ No

Dependent #1's name (First and Last) *please print*:_____

Dependent #1's date of birth: _____

Dependent #1's email address: _____

Dependent #1's signature: _____

Date: _____

Dependent #2

I authorize the release of my health record information ____ Yes ____ No

Dependent #2's name (First and Last) *please print*: _____

Dependent #2's date of birth: _____

Dependent #2's email address: _____

Dependent #2's signature: _____

Date: _____

Dependent #3

I authorize the release of my health record information ____ Yes ____ No

Dependent #3's name (First and Last) *please print*: _____

Dependent #3's date of birth: _____

Dependent #3's email address: _____

Dependent #3's signature: _____

Date: _____

Please note: Your consent is valid for one year from the date you sign this form.

Group Enrollment/Change/Cancellation Form

Minnesota/North Dakota/South Dakota/Wisconsin

INSTRUCTIONS

IMPORTANT – PLEASE READ BEFORE COMPLETING.

Please read and complete your enrollment/change/cancellation form thoroughly to ensure accurate processing.

- 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 **or fax to:** 1-248-733-6064

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).

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.

If you or your dependents have lost coverage under Medicaid or a State Children's Health Insurance Plan (SCHIP), you may be able to enroll yourself and/or your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' other coverage ends.

In addition, if you or your dependents become eligible for group health plan premium assistance provided by the Medicaid or SCHIP program, you may be able to enroll yourself and/or your dependents in this plan. You must request enrollment within 60 days after the date you or your dependents are determined to be eligible for premium assistance.

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 users, call 711).

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

Discrimination is Against the Law

Medica complies with applicable Federal civil rights laws and will not discriminate against any person on the basis of race, color, national origin, age, disability, or sex. Medica:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: TTY communication and written information in other formats (large print, audio, other formats).
- Provides free language services to people whose primary language is not English, such as: Qualified interpreters and information written in other languages.

If you need these services, call the number included in this document or on the back of your Medica ID card. If you believe that Medica has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Lori Braegelman, Civil Rights Coordinator, Mail Route CP250, PO Box 9310, Minneapolis, MN 55443-9310, 952-992-3422 (phone/fax), TTY 711, lori.braegelman@medica.com.

You can file a grievance in person or by mail, fax, or email. You may also contact the Civil Rights Coordinator if you need assistance with filing a complaint.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

If you want free help translating this information, call the number included in this document or on the back of your Medica ID card.

Si desea asistencia gratuita para traducir esta información, llame al número que figura en este documento o en la parte posterior de su tarjeta de identificación de Medica.

Yog koj xav tau kev pab dawb kom txhais daim ntawv no, hu rau tus xov tooj nyob hauv daim ntawv no los yog nyob nraum qab ntawm koj daim npav Medica ID.

如果您需要免費翻譯此資訊，請致電本文檔中或者在您的Medica ID卡背面包含的號碼。

Nếu quý vị muốn trợ giúp dịch thông tin này miễn phí, hãy gọi vào số có trong tài liệu này hoặc ở mặt sau thẻ ID Medica của quý vị.

Odeeffannoo kana gargaarsa tolaan akka isinii hiikamu yoo barbaaddan, lakkoobsa barruu kana keessatti argamu ykn ka dugda kaardii Waraqaa Eenyummaa Medica irra jiruun bilbila'a.

إذا كنت تريد مساعدة مجانية في ترجمة هذه المعلومات، فاتصل على الرقم الوارد في هذه الوثيقة أو على ظهر بطاقة تعريف ميديكا الخاصة بك.

Если Вы хотите получить бесплатную помощь в переводе этой информации, позвоните по номеру телефона, указанному в данном документе и на обратной стороне Вашей индентификационной карты Medica.

ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປຂໍ້ມູນນີ້ຟຣີ, ໃຫ້ໂທຫາເລກາໝາຍທີ່ມີຢູ່ໃນເອກະສານນີ້ ຫຼື ຢູ່ດ້ານຫຼັງຂອງບັດ Medica ຂອງທ່ານ.

이 정보를 번역하는 데 무료로 도움을 받고 싶으시면, 이 문서에 포함된 전화번호나 Medica ID 카드 뒷면의 전화번호로 전화하십시오.

Si vous voulez une assistance gratuite pour traduire ces informations, appelez le numéro indiqué dans ce document ou au dos de votre carte d'identification Medica.

နမ္ပါအဲဉီးတၢ်ကျိုးထံစၢၤကလီနှၢ်နၢ်တၢ်ဂုၢ်တၢ်ကျိုးအံၤလၢအကလီနှဉ်,ကိးလီတဲစိနီဉ်ဂ်ၢ်လၢအပဉ်ယုာ်လၢလံာ်တီလံာ်မီအပူၤအံၤမ့တမ့ၢ်ဖဲနနှနီဝေ လံာ်ဒုဉ်သးဒးက့အလိၢ်ခံတကပၤအဖီခိဉ်နှဉ်တက့ၢ်.

Kung nais mo ng libreng tulong sa pagsasalin ng impormasyong ito, tawagan ang numero na kasama sa dokumentong ito o sa likod ng iyong Kard ng Medica ID.

ይህን መረጃ ለመተርጎም ነጻ እርዳታ የሚፈልጉ ከሆነ በዝ ህ ሰነድ ዉስጥ ያለውን ቁጥር ወይም Medica መታወቅያ ካርድዎ በስተጀርባ ያለውን ይደውሉ።

Ako želite besplatnu pomoć za prijevod ovih informacija, nazovite broj naveden u ovom dokumentu ili na poleđini svoje ID kartice Medica.

Díí t'áá jíík'e shá ata' hodoonih nínízingo éí ninaaltsoosMedica bee néího'dílzinígí bine'déé' námboo biká'ígíijį' béésh bee hodíilnih.

Wenn Sie bei der Übersetzung dieser Informationen kostenlose Hilfe in Anspruch nehmen möchten, rufen Sie bitte die in diesem Dokument oder auf der Rückseite Ihrer Medica-ID-Karte angegebene Nummer an.

COMIFB 0716

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