Group Enrollment/Change/Cancellation Form

Minnesota, North Dakota, South Dakota, Wisconsin

Medica

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. You may have additional enrollment rights under applicable state law. For example, in Minnesota the notification period for dependent children is not limited to 30 days for newborns or children newly adopted or newly placed for adoption; however, Medica encourages you to request enrollment within 30 days.

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.

To obtain more information or request special enrollment, contact Medica Customer Service at **(952) 945-8000** or **1 (800) 952-3455** (TTY: **711**).

Visit us at **Medica.com**.

Group Enrollment/Change/Cancellation Form

Please type or print clearly.

	Group Number:

A EMPLOYEE INFORMATION

⚠ **If changing name or address, please enter new information**	Have you been a Medica member before? ❍ Yes ❍ No

First Name (Legal Name)[4] M.I.[4] Last Name[4]	Social Security Number[1]	Marital Status ❍ Single ❍ Married

Update	**Address (Must be a physical address, no P.O. Boxes)** [5]			
❍ Enroll ❍ Cancel ❍ Change	Street			
	City	State	ZIP Code	County

Contact Information [6]

Cellular/Home Telephone	Work Telephone	Email

Gender ❍ Male ❍ Female	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 & language:

Primary Care Clinic (Required for Medica Elect®)	Primary Care Clinic Identification (PCC ID) Number

B DEPENDENT INFORMATION

⚠ **List all members to be covered. Write name as it is stated on their Social Security card.**

	Check appropriate box	First name[4] M.I.[4] Last name[4] / Dependent's SSN	Gender	Birth Date (mm/dd/yy)	Relationship[2]	Full-time student?[3]	Required for Medica Elect
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 applicant's name as stated on their Social Security card, if they have a Social Security card.
5. Please ensure your full address is filled out, so you can receive important mailings, including your Medica ID card and welcome kit.
6. Phone numbers are important for outreach for a variety of programs that help support our members.

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.**

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 as necessary)
Start	**End**		

F MEDICARE INFORMATION

Are you, your spouse, or any of your dependents covered by Medicare? ❍ Yes ❍ No

If "yes" please complete the following:

Employee Medicare Information	**Spouse/Dependent Medicare Information**
Name:	**Name:**
Part A: ❍ Enrolled (Effective Date: _____ /_____ /_____)	**Part A:** Enrolled (Effective Date: _____ /_____ /_____)
Part B: ❍ Enrolled (Effective Date: _____ /_____ /_____)	**Part B:** ❍ Enrolled (Effective Date: _____ /_____ /_____)
Part D: ❍ Enrolled (Effective Date: _____ /_____ /_____)	**Part D:** ❍ Enrolled (Effective Date: _____ /_____ /_____)
Reason for Medicare eligibility:	**Reason for Medicare eligibility:**
❍ Over age 65 ❍ Kidney disease ❍ Disabled ❍ Disabled but actively at work	❍ 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 as a standalone plan through the insurance market.**

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

b. Changes

Date of Hire (required):	Requested Effective Date:
_____ /_____ /_____	_____ /_____ /_____

Check One:
- ❍ Name Change
- ❍ Return from leave/layoff
- ❍ Status change (PT/FT) _____ /_____ / _____
- ❍ Plan Change
- ❍ Address Change
- ❍ 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
- ❍ Medicare eligible
- ❍ Death
- ❍ COBRA Termination
- ❍ Divorce
- ❍ Dependent reached student/dependent maximum age
- ❍ Other (describe):

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

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: Civil Rights Coordinator, Mail Route CP250, PO Box 9310, Minneapolis, MN 55443-9310, 952-992-3422 (phone/fax), TTY 711, civilrightscoordinator@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, 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 document, call 1-800-952-3455.

Si desea recibir asistencia gratuita para la traducción de este documento, llame al 1-800-952-3455.

Yog koj xav tau kev pab dawb txhais daim ntawv no, hu rau 1-800-952-3455.

如果您需要我們免費幫您翻譯此文件，請致電 1-800-952-3455。

Nếu quý vị muốn giúp dịch tài liệu này miễn phí, gọi 1-800-952-3455.

Sanadnikun kaffaltiimaleeakkaisiniifhiikamuyoobarbaadd-an 1-800-952-3455 tiinbilbilaa.

إذا كنت ترغب في مساعدة مجانية لترجمة هذا المستند، فاتصل على الرقم1-800-952-3455.

Если вы хотите получить бесплатную помощь в переводе этого документа, позвоните по телефону 1-800-952-3455.

ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອຟຣີໃນການແປເອກະສານນີ້, ໃຫ້ໂທຫາ 1-800-952-3455.

이 문서를 번역하는 데 무료로 도움을 받고 싶으시면 1-800-952-3455로 전화하십시오.

Si vous désirez obtenir gratuitement de l'aide pour traduire ce document, appelez le 1 800 952 3455.

နမ့်လိဉ်ဘဉ်တ်မၤစၢၤကလီလၢတ်ကွဲးကျိာ်ထံလံာ်အံၤဧၣယိ, ကိး 1-800-952-3455.

Kung nais mo ng libreng tulong sa pagsasalin ng dokumentong ito, tumawag sa 1-800-952-3455.

ይህን ሰነድ ለመተርጎም ነጻ እርዳታ ከፈለጉ በ 1-800-952-3455 ይደውሉ።

Ako želite besplatnu pomoć za prijevod ovog dokumenta, nazovite 1-800-952-3455.

T'áá jiik'é díí naaltsoos t'áá nizaadk'ehjí bee shí ká'adoowoł ninízingo kojį' hodíílnih, 1-800-952-3455.

Wenn Sie kostenlose Hilfe zur Übersetzung dieses Dokuments wünschen, rufen Sie 1-800-952-3455 an.

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