

SMALL GROUP ENROLLMENT FORM



Please type or print clearly.

SEE BACK PAGE FOR INSTRUCTIONS

A. FOR EMPLOYER USE

Group Number	Multisite Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	Hire Date	Effective Date	Approved By/Date	Life Volume
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New Hire Special Enrollment Late Entrant Status Change _____ Return from leave/layoff _____

B. EMPLOYEE INFORMATION – This entire section must be completed even if you or your dependents DO NOT want coverage.

Employee's Social Security Number	Employer Name	Hire Date (Required)	Hours Worked Per Week
Employee's First Name	MI	Last Name	Primary Care Clinic / Clinic ID# (Medica Elect & Medica Essential only) / 00 - _____
Employee's Home Address — Street	City	County	State
			Zip Code
		Occupation/Job Title	Owner or Officer? <input type="checkbox"/> Yes <input type="checkbox"/> No
Home Phone	Work Phone & Extension	Cell Phone	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
			<input type="checkbox"/> Single <input type="checkbox"/> Married
		Height	Weight
			Date of Birth

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 _____

C. DEPENDENT INFORMATION – List all family members to be covered. Write name as it should appear on I.D. card.

- If currently enrolled and adding dependents, complete your information in Section B and dependent information in Section C.
- Student status information will be required for all family members who are age 19 or older.
- If dependent's address is different than employee's address, attach dependent's name and full address to this form.

First	Name/Social Security # M.I. Last	Relationship	Sex	Birthdate Month/Day/Year	Height	Weight	Full-time Student (Age 19+)	Primary Care Clinic and Clinic ID# (Medica Elect & Medica Essential only)
1)							<input type="checkbox"/> Yes <input type="checkbox"/> No School: _____	Name: _____ ID#: 00 - _____
	Social Security #:							
2)							<input type="checkbox"/> Yes <input type="checkbox"/> No School: _____	Name: _____ ID#: 00 - _____
	Social Security #:							
3)							<input type="checkbox"/> Yes <input type="checkbox"/> No School: _____	Name: _____ ID#: 00 - _____
	Social Security #:							
4)							<input type="checkbox"/> Yes <input type="checkbox"/> No School: _____	Name: _____ ID#: 00 - _____
	Social Security #:							
5)							<input type="checkbox"/> Yes <input type="checkbox"/> No School: _____	Name: _____ ID#: 00 - _____
	Social Security #:							

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) _____
 MNCare* Medical Assistance* CHAND* (Dates of coverage) _____
 Other _____
- *If waiving for Continuation (COBRA), MCHA, MNCare, South Dakota Risk Pool, CHAND or Medical Assistance, sections B, C, D and H must be completed.**
- 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.

_____/_____/_____
Date Signed

X _____
Employee Signature

E. COVERAGE AND BENEFIT OPTIONS – Please check all that apply.

- 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)
 I certify that I am eligible to participate in a Health Savings Account, then choose: Health Savings Account (HSA)
- 3) Dental – Administered and Underwritten by Delta Dental (if checked complete dental coverage level information)
Dental Coverage Level: Employee Only Employee + Spouse Employee + Child(ren) Employee + Family
- 4) Life AD&D (if checked complete beneficiary and relationship information)
Name of Beneficiary: _____ Relationship to Employee: _____
- 5) Dependent Life
- 6) To add dependents and employee, if applicable (write date of event in space provided)
 Marriage _____ Court Order (attached copy) _____ Birth/Adoption/Placement of Adoption _____

F. CURRENT & PREVIOUS COVERAGE – Failure to fully complete this section may result in a pre-existing condition limitation.

Important Note: 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.

- 1) Do you, or any family member listed on this form, have current health coverage or had previous health coverage within 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.

Date of Coverage (last 24 months)	Name of Insurance Company	Names of All Family Members Covered (use extra paper if necessary)
Start: ____ / ____ / ____ End: ____ / ____ / ____		
Start: ____ / ____ / ____ End: ____ / ____ / ____		
Start: ____ / ____ / ____ End: ____ / ____ / ____		
Start: ____ / ____ / ____ End: ____ / ____ / ____		
Start: ____ / ____ / ____ End: ____ / ____ / ____		

- 2) Have you been a Medica member before? Yes No
- 3) On the day your Medica coverage begins, will any family members be covered by any other health insurance or Medicare? Yes No
- 4) Are you or your spouse covered by Medicare? Part A or Part B Please attach copy of Medicare card or give effective dates.
- 5) Medicare eligibility due to: Age Kidney failure Disability Name of condition(s) _____

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 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. 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. 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.

_____/_____/_____
Date Signed

 X
Employee Signature

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.

SMALL GROUP ENROLLMENT FORM

Name _____

Employee Social Security Number _____-_____-_____

H. HEALTH INFORMATION – Required for all members applying for coverage.

Check every yes or no box and circle the medical condition(s) for all questions answered yes, for you and your family members applying for coverage.

- | | |
|---|--|
| <p>1. In the last 5 years, have you or your dependents had or been treated for:</p> <p>a. Diabetes or sugar, protein or blood in the urine?
Date diagnosed _____ last A1C reading _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b. High blood pressure _____ (last reading), chest pain, heart murmur, shortness of breath, angina, or other heart, blood or circulatory disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c. Stroke, multiple sclerosis, cerebral palsy, seizures, headaches or any disorder of the brain or nervous system? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>d. Asthma, allergies (receiving allergy shots? <input type="checkbox"/> Yes <input type="checkbox"/> No), emphysema, lung or respiratory disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>e. Digestive disorder, ulcer, hepatitis*; or any disorder of gallbladder, liver, stomach or intestines? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>f. Varicose veins, skin ulcerations, phlebitis, or hernia of any kind? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>g. Kidney, bladder, prostate or urinary disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>h. Disorder of breast or reproductive organs (male or female), infertility, or abnormal menstrual period? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>i. Rheumatoid arthritis, osteoarthritis, TMJ, or any disorder of the joints, muscles, back or bones? <input type="checkbox"/> Yes <input type="checkbox"/> No
Has surgery been performed? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, date? _____</p> <p>j. Cancer, tumor, cyst, or growth of any kind? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>k. Disorders relating to the immune system including HIV positive*, AIDS*, lupus, or any connective tissue disease? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>l. Any disorder of eyes, ears, nose or throat (excluding glasses)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>3. In the last 5 years, have you or your dependents:</p> <p>a. Been treated for alcohol or drug abuse? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b. Been seen for psychological disorders, anxiety, or eating disorders (circle all that apply) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c. Had any medical treatment, health, mental or physical impairment, surgery or congenital disorder, not mentioned above? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Is anyone:</p> <p>a. Currently receiving disability for workers' compensation or payments from an auto carrier for any injury? <input type="checkbox"/> Yes <input type="checkbox"/> No
final settlement received? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b. Currently disabled, hospitalized or on medical leave? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c. Currently receiving professional counseling? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, how often? _____</p> <p>5. Are any persons to be covered pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, list due date and if any complications or multiple births expected _____</p> <p>6. Has anyone in the last year (specify person):
Used tobacco or smokeless products? <input type="checkbox"/> Yes <input type="checkbox"/> No
Date ended _____</p> <p>7. Do you know of any pending or upcoming treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Has any surgery been recommended or advised in the future? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
|---|--|

2. Are you, or any of your dependents, taking or have taken any prescription drugs in the last year? Yes No
Please list the drug, dosage and for whom:

Person's Name	Drug Name	Condition	Currently Taking?	Dosage (How many taken each day)

EXPLAIN 'YES' ANSWERS TO ANY OF THE ABOVE QUESTIONS WITH COMPLETE DETAILS. **USE EXTRA PAPER IF NECESSARY.**

Question Number	Person's Name	Name of Condition	Currently Being Treated?	Date of Onset	Date of Recovery	Date Admitted to Hospital	Number of Days in Hospital

* You are not always required to disclose the performance of or results of a test to determine the presence of the HIV antibody or other bloodborne pathogens as described on the back cover of the enrollment form.

Instructions

IMPORTANT – PLEASE READ CAREFULLY

Upon completion, please fold form and staple at top to protect your privacy.

Please read your enrollment form thoroughly. If the following items are not completed, the processing of your enrollment form will be delayed.

1. Employer name.
2. Hire date.
3. Social Security numbers.
4. Name, full address and phone numbers.
5. Date of birth (month/day/year) for you and all eligible dependents.
6. If enrolling in Medica Elect or Medica Essential, you must complete your Primary Care Clinic selection.
7. Signature of employee and date signed.
8. Details to all health questions checked “Yes.”
9. Current and previous coverage information.

- **For MN residents only:** You are not required to disclose the performance of, or results of a test to determine the presence of the human immunodeficiency virus (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. Refer to the bottom of this page for a definition of terms marked with an asterisk (*).
- **If waiving medical coverage,** complete Sections B and D only. If waiving medical due to Continuation Coverage (COBRA), MCHA, MNCare, South Dakota Risk Pool, CHAND or Medical Assistance coverage, complete Sections B, C, D and H.
- For new enrollees, please submit the completed enrollment 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 B and your dependent’s information in all other sections.

Employers should send all completed forms to:

MEDICA
MN015-2803
P.O. Box 169063
Duluth, MN 55816

Broker note: If this is a new group submission, all forms should be directed to the Medica Sales Department.

DEFINED TERMS: The term “emergency medical services personnel” includes (1) individuals employed or receiving compensation to provide out-of-hospital emergency medical services such as a firefighter, paramedic, emergency medical technician, licensed nurse, rescue squad person, or other individual who serves as an employee or volunteer of an ambulance service as defined by Minnesota law or a member of an organized first responder squad that is formally recognized by a political subdivision in the state, who provides out-of-hospital emergency medical services during the performance of the individual’s duties; (2) an individual employed as a licensed peace officer under Minnesota law; (3) an individual employed as a crime laboratory worker while working outside the laboratory and involved in a criminal investigation; (4) any individual who renders emergency care or assistance at the scene of an emergency or while an injured person is being transported to receive medical care and who is acting as a good samaritan as described under Minnesota law; and (5) any individual who, in the process of executing a citizen’s arrest as defined by Minnesota law, may have experienced a significant exposure to a source individual*.

The term “bloodborne pathogen” means pathogenic microorganisms that are present in human blood and can cause disease in humans. These pathogens include, but are not limited to, hepatitis B virus (HBV), hepatitis C virus (HCV) and human immunodeficiency virus (HIV).

The term “source individual” means an individual, living or dead, whose blood tissue or potentially infectious body fluids may be a source of bloodborne pathogen exposure to an emergency medical services personnel. Examples include, but are not limited to, a victim of an accident, injury, or illness, or a deceased person.

The term “significant exposure” means contact likely to transmit a bloodborne pathogen, in a manner supported by the most current guidelines and recommendations of the United States Public Health Service at the time an evaluation takes place, that includes (1) percutaneous injury, contact of mucous membrane or nonintact skin, or prolonged contact of intact skin; and (2) contact, in a manner that may transmit a bloodborne pathogen, with blood, tissue, or potentially infectious body fluids.

MEDICA®

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