Minnesota/North Dakota/South Dakota

MEDICA®

NEW SMALL GROUP ENROLLMENT FORM

Please type or print clearly.
SEE BACK PAGE FOR INSTRUCTIONS

A. FOR EMPLOYER USE

Group Number	Hire Date	Effective Date	Approved By/Date

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 M.I. Last Name	Clinic Name / Clinic Number (Required for Medica Elect,® Medica Essential℠ and Medica Focus℠ only)

Employee's Home Address — Street City County State Zip Code	Occupation/Job Title	Owner or Officer? ❑ Yes ❑ No

Home Telephone	Work Telephone & Extension	Cellular Telephone	Sex ❑ Male ❑ Female	❑ Single ❑ 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:

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

C. DEPENDENT INFORMATION

- **List all family members to be covered. Write name as it should appear on I.D. card.**
- **If dependent's address is different than employee's address, attach dependent's name and full address to this form.**

Name/Social Security Number (Required) First M.I. Last	Relationship	Sex	Birth Date Month/Day/Year	Height	Weight	Full-time Student* (Age 19+)	**Clinic Name and Clinic Number (Required for Medica Elect, Medica Essential and Medica Focus only)**
1) Social Security Number:						❑ Yes ❑ No School:	Clinic Name: Clinic Number: _ _ _ _ _ _ _
2) Social Security Number:						❑ Yes ❑ No School:	Clinic Name: Clinic Number: _ _ _ _ _ _ _
3) Social Security Number:						❑ Yes ❑ No School:	Clinic Name: Clinic Number: _ _ _ _ _ _ _
4) Social Security Number:						❑ Yes ❑ No School:	Clinic Name: Clinic Number: _ _ _ _ _ _ _
5) Social Security Number:						❑ Yes ❑ No School:	Clinic Name: Clinic Number: _ _ _ _ _ _ _

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

D. WAIVER OF MEDICAL COVERAGE

This entire section must be completed even 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
❑ Medicare
❑ MinnesotaCare*
❑ Other ____________________
❑ Individual Policy
❑ Group Coverage Continuation (COBRA)*
❑ Medical Assistance*
❑ MCHA* (Dates of coverage) ____________________
❑ South Dakota Risk Pool* (Dates of coverage) ____________________
❑ CHAND* (Dates of coverage) ____________________

***If waiving for Continuation (COBRA), MCHA, MinnesotaCare, South Dakota Risk Pool, CHAND or Medical Assistance, sections B, C, D and F 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.

Employee Signature: X ____________________ Date Signed: ____________________

(only sign if you are waiving coverage)

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)

F. 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.

	Yes	No
1. In the last 5 years, have you or your dependents had or been treated for:		
a. Diabetes or sugar, protein or blood in the urine? Date diagnosed _______________ last A1C score ________________	❑	❑
b. High blood pressure _______________ (last reading), chest pain, heart murmur, shortness of breath, angina, or other heart, blood or circulatory disorder?	❑	❑
c. Stroke, multiple sclerosis, cerebral palsy, seizures, headaches or any disorder of the brain or nervous system?	❑	❑
d. Asthma, allergies (receiving allergy shots? ❑ Yes ❑ No), emphysema, lung or respiratory disorder?	❑	❑
e. Digestive disorder, ulcer, hepatitis*; or any disorder of gallbladder, liver, stomach or intestines?	❑	❑
f. Varicose veins, skin ulcerations, phlebitis, or hernia of any kind?	❑	❑
g. Kidney, bladder, prostate or urinary disorder?	❑	❑
h. Disorder of breast or reproductive organs (male or female), infertility, or abnormal menstrual period?	❑	❑
i. Rheumatoid arthritis, osteoarthritis, TMJ, or any disorder of the joints, muscles, back or bones?	❑	❑
Date and type of muskuloskeletal surgery performed ____		
j. Cancer, tumor, cyst, or growth of any kind?	❑	❑
k. Disorders relating to the immune system including HIV positive*, AIDS*, lupus, or any connective tissue disease?	❑	❑
l. Any disorder of eyes, ears, nose or throat (excluding glasses)?	❑	❑

	Yes	No
2. In the last 5 years, have you or your dependents:		
a. Been treated for alcohol or drug abuse?	❑	❑
b. Been seen for psychological disorders, anxiety, or eating disorders?	❑	❑
c. Had any medical treatment, health, mental or physical impairment, surgery or congenital disorder, not mentioned above?	❑	❑
3. Is anyone:		
a. Currently receiving disability for workers' compensation or payments from an auto carrier for any injury?	❑	❑
If yes, final settlement received?	❑	❑
Is ongoing treatment needed?	❑	❑
b. Currently disabled, hospitalized or on medical leave?	❑	❑
c. Currently receiving professional counseling?	❑	❑
If yes, how often? ____		
4. Are any persons to be covered pregnant?	❑	❑
If yes, list due date ____		
How many births expected?_____________________________________		
Any complications currently or expected?	❑	❑
5. Has anyone in the last year (specify person):		
Used tobacco or smokeless products?	❑	❑
Name____________________________ Date ended ________________		
Name____________________________ Date ended ________________		
6. Do you know of any pending or upcoming treatment?	❑	❑
7. Has any surgery been recommended or advised in the future?	❑	❑

EXPLAIN 'YES' ANSWERS TO ANY OF THE ABOVE QUESTIONS WITH COMPLETE DETAILS. **ATTACH ADDITIONAL SHEET IF NECESSARY.**

Question Number	Person's Name	Name of Condition	Currently Being Treated?	Date of Onset	Date Last Treated	Date of Last Hospitalization	Total Number of Days in Hospital	Number of Hospital Stays

8. Are you, or any of your dependents, taking or have taken any prescription drugs in the last year? Please list the drug, dosage and for whom:

Person's Name	Drug Name	Name of Condition	Currently Taking?	How many per day	Dosage
			❑ Yes ❑ No		
			❑ Yes ❑ No		
			❑ Yes ❑ No		
			❑ Yes ❑ No		
			❑ Yes ❑ No		

* 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.

G. 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:		

H. 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

I. 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

J. 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.

INSTRUCTIONS

IMPORTANT – PLEASE READ CAREFULLY

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

Please complete 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 telephone numbers.
5. Date of birth (month/day/year) 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. Current and previous coverage information.

- **If waiving medical coverage,** complete Sections B and D.
- For new enrollees, please submit the completed enrollment form to your employer.

Broker note: All new group submissions should be directed to the Medica Sales Department.

Twin Cities Metro Office:
Mail Route CP275
401 Carlson Parkway
Minnetonka, MN 55305

Duluth Office:
Suite 512
130 W. Superior St.
Duluth, MN 55802

Fargo Office:
Suite 210
1711 Gold Drive South
Fargo, ND 58103

St. Cloud Office
Suite 160
818 Second Street South
Waite Park, MN 56387

Sioux Falls Office:
Suite 200
110 South Phillips Avenue
Sioux Falls, SD 57104

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.

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

MEDICA®

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COM5084-40409