

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. 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 Glencoe-Silver Lake benefits administrator.

Group Enrollment/Change/Cancellation Form



Please type or print clearly.

Enter Effective Date:

SECTION

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)	M.I.	Last Name	Social Security Number	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married
-------------------------	------	-----------	------------------------	---

Update	Address (Must be a physical address, no P.O. Boxes)			
<input type="checkbox"/> Enroll	Street			
<input type="checkbox"/> Cancel				
<input type="checkbox"/> Change	City	State	ZIP Code	County

Contact Information		
Cellular/Home Telephone	Work Telephone	Email

Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Birth date (mm/dd/yy)	Do you or any of your dependents speak a language other than English as your primary language? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" please list name & language:
--	-----------------------	--

SECTION

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	M.I.	Last name	Gender	Birth Date (mm/dd/yy)	Relationship Spouse or Child	Full-time student?
	Dependent's SSN						
1	<input type="checkbox"/> Enroll			<input type="checkbox"/> M			<input type="checkbox"/> Yes
	<input type="checkbox"/> Cancel	SS#		<input type="checkbox"/> F			<input type="checkbox"/> No
2	<input type="checkbox"/> Enroll			<input type="checkbox"/> M			<input type="checkbox"/> Yes
	<input type="checkbox"/> Cancel	SS#		<input type="checkbox"/> F			<input type="checkbox"/> No
3	<input type="checkbox"/> Enroll			<input type="checkbox"/> M			<input type="checkbox"/> Yes
	<input type="checkbox"/> Cancel	SS#		<input type="checkbox"/> F			<input type="checkbox"/> No
4	<input type="checkbox"/> Enroll			<input type="checkbox"/> M			<input type="checkbox"/> Yes
	<input type="checkbox"/> Cancel	SS#		<input type="checkbox"/> F			<input type="checkbox"/> No

- 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.

SECTION **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: _____

Please return this completed form to Glencoe Silver-Lake benefits administrator for processing.