GROUP ENROLLMENT/CHANGE/CANCELLATION FORM
Minnesota Healthcare Consortium

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 completed forms through fax or secure site email:

- **Fax:** 1-317-222-3003
- **Secure site email:** Sign in to our secure website by clicking on the following link: **Capstone Benefits – MHC Enrollment Administration**. You'll register as a new user the first time you sign in and you'll receive an email confirming your credentials. To send your enrollment form, compose a new message in the site, attach the Employee Enrollment Form and send to **MHC@CapstoneBenefits.com** in the secure site.

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 employ-er 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 your-self 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 users, call 711).

Visit us at **Medica.com**.

Group Enrollment/Change/Cancellation Form

Please type or print clearly.

Group Number:

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)[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

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[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.

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SECTION C

PRODUCT SELECTION

❑ Medical Plan - If your employer offers you a choice of Medical plans, please write your Medical plan selection here:

SECTION 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

SECTION 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 as necessary)
Start: End:		
Start: End:		
Start: End:		
Start: End:		
Start: End:		

SECTION F

MEDICARE INFORMATION

1. Are you, your spouse, or any of your dependents covered by Medicare? ❑ Yes ❑ No

If "yes" please attach a copy of each Medicare ID card and 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

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: _____

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SECTION **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: Fax to 1-317-222-3003 or sign in and send an email from the secure website at **Capstone Benefits – MHC Enrollment Information.**

THIS PAGE TO BE COMPLETED BY EMPLOYER - RETURN ALL PAGES TO CAPSTONE ADMINISTRATORS