Group Enrollment/Change/Cancellation Form

Minnesota, North 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 211041, Eagan, MN 55121 or fax to: 844-280-3838

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]			
Primary phone	Email (required)		
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®) NA	Primary Care Clinic Identification (PCC ID) Number NA		

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[1]	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 may be contacted by the IRS and/or Medica asking you to verify your SSN if needed for 1094/1095 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 ❍ CHAND (dates of coverage):
❍ Medicare ❍ Group Coverage Continuation (COBRA) ❍ Other:
❍ MinnesotaCare ❍ Medical Assistance

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.

	Names of all members covered (use extra paper as necessary)	**Name of Insurance Company**	**Insurance Company Address**
1			
2			
3			
4			
5			

	City	**State**	**Zip Code**
1			
2			
3			
4			
5			

	Policyholder name	**Policyholder DOB**	**Policy ID**	**Date of Coverage**	
				Start	**End**
1					
2					
3					
4					
5					

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 act, practice or omission performed by Us that constitutes fraud may result in the denial of claims or cancellation or retroactive termination of my or my dependents' 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 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 an intentional misrepresentation or omission of material fact 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 of transaction.
3. Provide approval and signature in Section 3.

1: Group Information

Employer Name	Group Number
Condor Corporation	
◪ Active ❍ COBRA ❍ Retired Date: _____ /_____ /_____	Department Number

2: Enrollment Action Requested

a. New Enrollment/Additions

Date of Hire (required):	Requested Effective Date:
_____ /_____ /_____	4 ____ /1 ____ /26 ____

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 211041, Eagan, MN 55121 **or fax to** 844-280-3838

THIS PAGE TO BE COMPLETED BY EMPLOYER - RETURN ALL PAGES TO MEDICA

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English: ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-952-3455 (TTY: 711) for Medica, call 1-877-317-2410 (TTY: 711) for Dean Health Plan/Prevea360 Health Plan, or speak to your provider.

Spanish: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia de idiomas. También están disponibles de forma gratuita asistencia y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-800-952-3455 (TTY: 711) para Medica, llame al 1-877-317-2410 (TTY: 711) para Dean Health Plan/Prevea360 Health Plan o hable con su proveedor de atención médica.

Vietnamese/Việt: LƯU Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-800-952-3455 (TTY: 711) đối với Medica, gọi theo số 1-877-317-2410 (TTY: 711) đối với Dean Health Plan/Prevea360 Health Plan hoặc trao đổi với nhà cung cấp dịch vụ của quý vị.

Chinese Traditional: 注意：如果您說中文，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-800-952-3455 (TTY: 711) 聯絡 Medica，致電 1-877-317-2410 (TTY: 711) 聯絡 Dean Health Plan/Prevea360 Health Plan，或與您的提供者討論。

Hmong/Lus Hmoob: LUS CEEV: Yog hais tias koj hais Lus Hmoob ces muaj kev pab txhais lus pub dawb rau koj. Muaj khoom siv thiab muaj kev saib xyuas pab uas tsim nyog los npaj kom muaj cov ntaub ntawv uas siv tau dawb. Hu rau 1-800-952-3455 (TTY: 711) rau Medica, hu rau 1-877-317-2410 (TTY: 711) rau Dean Health Plan/Prevea360 Health Plan, los sis tham rau koj tus kws kuaj mob.

German/Deutsch: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-800-952-3455 (TTY: 711) für Medica bzw. 1-877-317-2410 (TTY: 711) für Dean Health Plan/Prevea360 Health Plan oder sprechen Sie mit Ihrem Gesundheitsdienstleister.

Cushitic-Oromo: XIYYEEFFANNOO: Ingiliffaa dubbattu taanaan, tajaajilli deggersa afaan bilisaa ni jira. Tajaajilli deggersa bu'ura dhiheessii odeeffannoo kaffaltii tokko malee ni jira. Lakkoofsa bilbilaa 1-800-952-3455 (TTY: 711) Tajaajila Fayyaaf, lakkoofsa Medica 1-877-317-2410 (TTY: 711), Dean Health Plan/Prevea360 Health Plan, ykn dhiheessaa keessan dubbisaa.

العربية/Arabic

كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. تنبيه: (الهاتف النصي: 711) للتواصل مع 1-800-952-3455اتصل على الرقم المعلومات بتنسيقات يمكن الوصول إليها مجانًا. Medica، اتصل على الرقم 1-877-317-2410 (الهاتف النصي: 711) بشأن خطة الرعاية الصحية Dean Health Plan/Prevea360 Health Plan

Y0088_1015697_C H9096_1015697_C H8019_1015697_C H5264_1015697_C

Korean/한국어: 주의: 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. Medica 의 경우 1-800-952-3455(TTY: 711)번으로, Dean Health Plan/Prevea360 Health Plan 의 경우 1-877-317-2410(TTY: 711)번으로 전화하시거나, 서비스 제공업체에 문의하십시오.

Russian/Русский: Если вы говорите по-русски, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-952-3455 (TTY: 711) относительно Medica, позвоните по телефону 1-877-317-2410 (TTY: 711) относительно Dean Health Plan/Prevea360 Health Plan или обратитесь к своему поставщику услуг.

Laos/ ລາວ: ຂໍ້ຄວນເອົາໃຈໃສ່: ຖ້າທ່ານເວົ້າພາສາລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ນອກຈາກນີ້ ຈະມີເຄື່ອງຊ່ວຍເສີມ ແລະ
ບໍລິການແບບທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້ໂດຍບໍ່ເສຍຄ່າ. ໂທຫາເບີ 1-800-952-3455 (TTY: 711) ສຳລັບ Medica, ໂທ 1-877-317-2410 (TTY: 711) ສຳລັບ Dean Health Plan/Prevea360 Health Plan ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.

French/ Français: ATTENTION : si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-952-3455 (TTY : 711) pour Medica, appelez le 1-877-317-2410 (TTY : 711) pour le régime de santé Dean Health Plan/Prevea360, ou parlez à votre prestataire de santé.

Serbo-Croatian: PAŽNJA: Ako govorite srpski, dostupne su vam besplatne usluge tumača. Odgovarajuća dodatna pomagala i usluge za pružanje informacija u pristupačnim formatima su takođe dostupne besplatno. Za Medica zdravstveno osiguranje pozovite 1-800-952-3455 (TTY: 711), za Dean/Prevea360 zdravstveno osiguranje pozovite 1-877-317-2410 (TTY: 711) ili razgovarajte sa svojim pružaocem usluga.

Tagalog: PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-952-3455 (TTY: 711) para sa Medica, tumawag sa 1-877-317-2410 (TTY: 711) para sa Dean Health Plan/Prevea360 Health Plan, o makipag-usap sa iyong tagapagbigay ng serbisyo.

Karen/ထၢးနှာ်လီၤဖဲအံၤ: ဟ်သူဉ်ဟ်သး– နမ့ၢ်ကတိၤကညီကျိာ်နၣ် တၢ်အိဉ်ဒီး ကျိာ်တၢ်ဆိဉ်ထွဲမၤစၢၤ လၢတလာ်ဘူဉ်လာ်စ့ၤလၢနဂီၢ်လီၤ. တၢ်အိဉ်ဒီး ပှၤနီၢ်ခိကွၢ်ဂီၤတဆူဉ်တကျၢၤအဂီၢ်
ပီးလိဒီးတၢ်တိစၢၤမၤစၢၤလၢအကြားအဘဉ် လၢကဟ့ဉ်တၢ်ဂ့ၢ်တၢ်ကျိၤ လၢတၢ်မၤနှ့ၢ်အီၤသ့တဖဉ် လၢတလာ်ဘူဉ်လာ်စ့ၤ လၢနဂီၢ်လီၤ. ကိး 1-800-952-3455 (TTY: 711) လၢ Medica အဂီၢ်, ကိး 1-877-317-2410 (TTY: 711) လၢ Dean Health Plan/Prevea360 Health Plan အဂီၢ်, မ့တမ့ၢ် ကတိၤတၢ်ဒီး နပှၤလၢဟ့ဉ်နၤတၢ်ကွၢ်ထွဲတကွၢ်.

Amharic/ አማርኛ:- ማሳሰቢያ፡- አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ድጋፍ አገልግሎት በነፃ ይቀርብልዎታል። መረጃን በተደራሽ ቅርጸት ለማቅረብ ተገቢ የሆኑ ተጨማሪ እገዛዎች እና አገልግሎቶች እንዲሁ በነፃ ይገኛሉ። ለMedica በ1-800-952-3455 (TTY: 711) ይደውሉ፣ ለDean የጤና እቅድ/Prevea360 የጤና እቅድ በ1-877-317-2410 (TTY: 711) ይደውሉ ወይም ለእርስዎን አቅራቢ የሆነውን ያነጋግሩ።