# Employee Application

Iowa/Minnesota/Nebraska/North Dakota/South Dakota/Wisconsin

Medica

**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 C.
- For new enrollees, please submit this completed application to your employer.

**Employers should send all completed forms to their Medica representative.**

## 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.

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.

You may have additional enrollment rights under applicable state law. 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**.

# Employee Application

Please type or print clearly.

| Group Name: | Group Number: | Department Number: |
|---|---|---|
| | | |

## A EMPLOYEE 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 |
|---|---|---|
| | | |

**Mailing Address**

| Street | | | |
|---|---|---|---|
| City | State | ZIP Code | County |
| | | | |

**Contact Information [6]**

| Cellular/Home Telephone | Work Telephone | Email |
|---|---|---|
| | | |

| Gender ❍ Male ❍ Female | Birth date (mm/dd/yy) | Height: ___ ft. ___ in. Weight: _____ lbs. | 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 |
|---|---|
| | |

## B DEPENDENT INFORMATION

| Check appropriate box | | ⚠ List all members to be covered. Write name as it should appear on the ID card. First name[4] M.I.[4] Last name[4] / Dependent's SSN[1] | Gender | Height / Weight | Birth Date (mm/dd/yy) / Relationship[2] | Full-time student? [3] | Required for Medica Elect |
|---|---|---|---|---|---|---|---|
| 1 | ❍ Enroll ❍ Cancel ❍ Change | | ❍ M ❍ F | __ ft. __ in. / __ lbs. | | ❍ Yes ❍ No | PCC name: / PCC ID: |
| | | SS# | | | | | |
| 2 | ❍ Enroll ❍ Cancel ❍ Change | | ❍ M ❍ F | __ ft. __ in. / __ lbs. | | ❍ Yes ❍ No | PCC name: / PCC ID: |
| | | SS# | | | | | |
| 3 | ❍ Enroll ❍ Cancel ❍ Change | | ❍ M ❍ F | __ ft. __ in. / __ lbs. | | ❍ Yes ❍ No | PCC name: / PCC ID: |
| | | SS# | | | | | |
| 4 | ❍ Enroll ❍ Cancel ❍ Change | | ❍ M ❍ F | __ ft. __ in. / __ lbs. | | ❍ Yes ❍ No | PCC name: / PCC ID: |
| | | SS# | | | | | |

**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.

## C 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**

## D HEALTH INFORMATION

**Required for all members applying for coverage.** You should not include any genetic information. That is, please do not include any information related to genetic testing, genetic services, genetic counseling or genetic diseases, or any medical history or medical information for family members who are not 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.

**1. In the last 5 years, have you or your dependents been diagnosed with or been treated for:**

a. Diabetes or sugar, protein or blood in the urine? ❍ Yes ❍ No
Date diagnosed _____ Last A1C score _____
b. Asthma, allergies (receiving allergy shots? ❍ Yes ❍ No), emphysema, lung or respiratory disorder? ❍ Yes ❍ No
c. Digestive disorder, ulcer, hepatitis*; or any disorder of gallbladder, liver, stomach or intestines? ❍ Yes ❍ No
d. Varicose veins, skin ulcerations, phlebitis, or hernia of any kind? ❍ Yes ❍ No
e. Kidney, bladder, prostate or urinary disorder? ❍ Yes ❍ No
f. Disorder of breast or reproductive organs (male or female), infertility or abnormal menstrual period? ❍ Yes ❍ No
g. Rheumatoid arthritis, osteoarthritis, TMJ, or any disorder of the joints, muscles, back or bones? ❍ Yes ❍ No
Date and type of muskuloskeletal surgery performed _____
h. Any disorder of eyes, ears, nose or throat (excluding glasses)? ❍ Yes ❍ No

**2. Have you or your dependents EVER been diagnosed with or been treated for:**

a. High blood pressure (last reading: _____), chest pain, heart murmur, shortness of breath, angina or other heart, blood or circulatory disorder? ❍ Yes ❍ No
b. Stroke, multiple sclerosis, cerebral palsy, seizures, headaches or any disorder of the brain or nervous system? ❍ Yes ❍ No
c. Cancer, tumor, cyst or growth? (stage of growth) ❍ Yes ❍ No
Spread to lymph nodes? ❍ Yes ❍ No
d. Disorders relating to the immune system including HIV positive*, AIDS*, lupus or any connective tissue disease? ❍ Yes ❍ No

**3. In the last 5 years, have you or your dependents:**

a. Been treated for alcohol or drug abuse? ❍ Yes ❍ No
b. Been seen for psychological disorders, anxiety or eating disorders? ❍ Yes ❍ No
c. Had any medical treatment, health, mental or physical impairment, surgery or congenital disorder, not mentioned above? ❍ Yes ❍ No

## D HEALTH INFORMATION (CONTINUED)

**4. Are you or your dependents:**

a. Currently receiving disability for workers' compensation or payments from an auto carrier for an injury? ❍ Yes ❍ No
If yes, final settlement received? ❍ Yes ❍ No
Is ongoing treatment needed? ❍ Yes ❍ No

b. Currently disabled, hospitalized or on medical leave? ❍ Yes ❍ No

c. Currently receiving professional counseling? ❍ Yes ❍ No
If yes, how often? _____

**5. Are any persons to be covered pregnant?** ❍ Yes ❍ No
If yes, list due date: _____
How many births expected? _____
Any complications currently or expected? _____

**6. Has anyone in the last year (specify person):**
Used tobacco or smokeless products? ❍ Yes ❍ No
Name: _____ Date ended: _____
Name: _____ Date ended: _____

**7. Do you know of any pending or upcoming treatment?** ❍ Yes ❍ No

**8. Has any surgery been recommended or advised in the future?** ❍ Yes ❍ No

**9. Have you taken any IV or injectible drugs in the past year?** ❍ Yes ❍ No
If yes, are you still taking it? ❍ Yes ❍ No

**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 # of Days in Hospital | Number of Hospital Stays |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| | | | | | | | | |
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**10. Are you, or any ofyour dependents, taking or have taken prescription drugs in the last year?** ❍ Yes ❍ No
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 | | |
| | | | ❍ Yes ❍ No | | |

*You are not required to disclose 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.

## E DEFINED TERMS

The term "**emergency medical services personnel**" includes:

(1) An individual 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 state 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 state 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 state law; and

(5) Any individual who, in the process of executing a citizen's arrest as defined by state law, may have experienced a significant exposure to a source individual.

The term "**bloodborne pathogen**" means pathogenic microorganisms that are present in the 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 blood-borne pathogen, with blood, tissue, or potentially infection body fluids.

## F 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.

| Date of Coverage | | Name of Insurance Company | Names of all members covered (use extra paper as necessary) |
|---|---|---|---|
| Start | End | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## G MEDICARE INFORMATION

Are you, your spouse or any dependents covered by Medicare? ..... ❍ Yes ❍ No

If "Yes," please 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

## H 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 knowlingly 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 of 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: _____

## Discrimination is Against the Law

Medica complies with applicable Federal civil rights laws and will not discriminate against any person on the basis of race, color, national origin, age, disability or sex. Medica:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: TTY communication and written information in other formats (large print, audio, other formats).
- Provides free language services to people whose primary language is not English, such as: Qualified interpreters and information written in other languages.

If you need these services, call the number included in this document or on the back of your Medica ID card. If you believe that Medica has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Civil Rights Coordinator, Mail Route CP250, PO Box 9310, Minneapolis, MN 55443-9310, 952-992-3422 (phone/fax), TTY 711, civilrightscoordinator@medica.com.

You can file a grievance in person or by mail, fax, or email. You may also contact the Civil Rights Coordinator if you need assistance with filing a complaint.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

## If you want free help translating this document, call 1-800-952-3455.

Si desea recibir asistencia gratuita para la traducción de este documento, llame al 1-800-952-3455.

Yog koj xav tau kev pab dawb txhais daim ntawv no, hu rau 1-800-952-3455.

如果您需要我們免費幫您翻譯此文件，請致電 1-800-952-3455。

Nếu quý vị muốn giúp dịch tài liệu này miễn phí, gọi 1-800-952-3455.

Sanadnikun kaffaltiimaleeakkaisiniifhiikamuyoobarbaadd-an 1-800-952-3455 tiinbilbilaa.

إذا كنت ترغب في مساعدة مجانية لترجمة هذا المستند، فاتصل على الرقم 1-800-952-3455.

Если вы хотите получить бесплатную помощь в переводе этого документа, позвоните по телефону 1-800-952-3455.

ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອຟຣີໃນການແປເອກະສານນີ້, ໃຫ້ໂທຫາ 1-800-952-3455.

이 문서를 번역하는 데 무료로 도움을 받고 싶으시면 1-800-952-3455로 전화하십시오.

Si vous désirez obtenir gratuitement de l'aide pour traduire ce document, appelez le 1 800 952 3455.

နမ့်လိ်ဉ်ဘဉ်တ်မၤစၢၤကလီလၢတ်ကွဲးကျိာ်ထံလံာ်အံၤအဃိ, ကိး 1-800-952-3455.

Kung nais mo ng libreng tulong sa pagsasalin ng dokumentong ito, tumawag sa 1-800-952-3455.

ይህን ሰነድ ለመተርጎም ነጻ እርዳታ ከፈለጉ በ 1-800-952-3455 ይደውሉ።

Ako želite besplatnu pomoć za prijevod ovog dokumenta, nazovite 1-800-952-3455.

T'áá jiik'é díí naaltsoos t'áá nizaadk'ehjí bee shí ká'adoowoł ninízingo kojį' hodíílnih, 1-800-952-3455.

Wenn Sie kostenlose Hilfe zur Übersetzung dieses Dokuments wünschen, rufen Sie 1-800-952-3455 an.

COMIFB-0119-K

Medica