Minnesota/North Dakota/South Dakota

NEW SMALL GROUP ENROLLMENT FORM

Please type or print clearly. SEE BACK PAGE FOR INSTRUCTIONS

A. FOR EMPLOYER US	E							<u> </u>	L BACK	TAC	ETORT	None	HONS
Group Number		Hire Date			Effective Date				Approved By/Date				
	447.01												
B. EMPLOYEE INFORM	MATION												
This entire section must b	e completed e	ven if you o	r your	depende	ents DO	O NOT v	want cove	age.					
Employee's Social Security Number	Employer	yer Name				Hire Date (Requ			uired) Hour			Worked Per Week	
Employee's First Name M.I. Last Name Clinic Name / Clinic Number (Required for Medica Elect,® Medica Essential SM and Medica Focus SM only)													
1 7							'		•				,,
Employee's Home Address — Stree	 County State Zip C					 de	cupation/Job Title			Owner or	☐ Yes		
1 7	et City	outy ou				,						Officer?	□No
Home Telephone Work Te	elephone & Extensi	tension Cellular Telephone				Male Female	☐ Single☐ Marrie		ght	t Weight		Date of Bi	rth
												5.11	
Do you or any of your dependents		other than En	glish as	your prima	ary langi	uage?						⊔ Yes	s ⊔ No
If yes, please list name and language													
Have you been a Medica member												Ll Yes	s U No
C. DEPENDENT INFOR													
• List all family members in the state of th								d full a	ddraes t	n this	form		
— The dependent's address	is different than	remployee	s auu	less, atta	cii dep	endent						d Clinic Num	hor
Name/Social Security Number		D 1 1.	6	Birth D				Stud	dent*	(Requ	ired for M	edica Elect,	Medica
First M.I.	Last	Relationship	Sex	Month/Da	ay/Year	Height	Weight					edica Focus	only)
1)								School:	□ No		nic Name:		
Social Security Number:								DV	DN				
2)								School:			Name:		
Social Security Number:							DV						
3)							School:	□No	Clinic Name:				
Social Security Number:								☐ Yes ☐ No		Clinic Number:			
4)								School:		Clinic Name: Clinic Number:			
Social Security Number:													
5)								School:			Name:		
Social Security Number: * This field is not required by Medica. Medica does not administer student status verification, however your employer ma													
			stuaent	status veri	fication,	nowever	your emplo	yer may	request this	s intor	mation for	tneir record	S.
D. WAIVER OF MEDIC													
This entire section must b								age.					
1) I understand that I am eligible • Me and my dependents	for coverage three My spouse	ough my emp My deper	-		Γ want α	coverage	for:						
2) The reason I am declining cover	-	is because I	or my			_	•	_					
□ Spouse's group plan □ Individual Policy □ MCHA* (Dates of coverage)													
☐ MinnesotaCare* ☐ Medical Assistance* ☐ CHAND* (Dates of coverage)													
Other				_						_			
*If waiving for Continuation (COB													
3) I understand that if I decide to own expense) and that a pre-e		-		-	y aeper	idents m	ay be requi	rea to s	upmit add	aitiona	ai nealth ir	irormation	(at my
Employee Signature: X		Date Signed:											

	mall Group E				Nam	e			So	cial S	ecurity Nu	mber		
$\overline{}$			ENEFIT OPTI	ONS										
_	ase check all tha													
1) Medical Benefit Plan Name: Medical Coverage Level: Employee Only Employee 2) Medica Direct® Selection				oouse	<u></u>	Employee + (Child(ren)	□ Er	mployee +	Family				
☐ Hea	alth Reimbursemen	t Arran	gement (HRA)	☐ Flexible S	pend	ding Acco	unt (F	FSA)						
F. HI	EALTH INFO	ORM	ATION											
_			s applying for co	verage.										
_			the medical condition		stion	s answered	d yes,	for you and yo	ur family membe	ers app	olying for co	verage.		
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				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?								
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),			<u> </u>											
emphysema, lung or respiratory disorder? e. Digestive disorder, ulcer, hepatitis*; or any disorder of gallbladder, liver, stomach or intestines?				٥										
 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? 			<u> </u>		_									
				5. Has anyone in the last year (specify person):										
Date and type of muskuloskeletal surgery performed						ame ame								
k. Disc	6*, lupus, or any conr	immune nective t	system including HIV				6. D	o you know of	any pending or been recomme	upco	ming treatn	nent?		
EXPLAIN	'YES' ANSWERS	TO AN	IY OF THE ABOVE	QUESTIONS	WITI	H COMPL	ETE	DETAILS.	ATTA	CH AI	DDITIONA	L SHEET IF NEC	ESSARY	
Question Number	Person's Name		Name of Con	dition	•	Currently E Treated	_	Date of Onset	Date Last Treated		te of Last pitalization	Total Number of Days in Hospital	Numbe Hospital	
8. Are you		oenden	ts, taking or have tak		otion	drugs in th	e las	t year? Please	list the drug, do	sage	and for who			
Person's Name Drug Name									Dosa	ige				
									☐ Yes ☐					
											☐ 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.

Nev	w Small Group Enrollment Form	Name	Social Security Number
G.	CURRENT & PREVIOUS COVERAGE	GE	
(!)	Failure to complete this section may result in to our plan, you might have to wait a certain	a pre-existing condition limitation period of time before the plan wi	n. This means that if you have a medical condition before coming Il provide coverage for that condition.
	Do you, or any family member listed on this for		have you, or any family member listed Yes No
	If "Yes," you must fully complete the following	section. Starting with the employee	, list each family member applying for coverage and include verage is still in effect, please write "current" or "present" in the
	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:		
Н.	COORDINATION OF BENEFITS		
(!)	Failure to complete this section may result in	a delay in the processing of your	claims.
	On the day your Medica coverage begins, will Medical coverage?		ve dual health insurance or 🗀 Yes 🗅 No
I. N	MEDICARE INFORMATION		
	Are you, your spouse or any dependents cover If "Yes," please attach a copy of each Medicare		
	Employee Medicare Information:	Spouse/Dependent	Medicare Information: Name:
	Part A: ☐ Enrolled (Effective Date:/_ Part B: ☐ Enrolled (Effective Date:/_		(Effective Date: /)
	Part B: ☐ Enrolled (Effective Date:/_ Part D: ☐ Enrolled (Effective Date:/_	•	(Effective Date: /) (Effective Date: /)
	Reason for Medicare eligibility:	Reason for Medicare	
	☐ Over age 65 ☐ Kidney disease ☐ Disabled☐ Disabled but actively at work	□ Over age 65 □ Ki □ Disabled but active	dney disease □ Disabled ely at work
J. I	EMPLOYEE AUTHORIZATION & REP	RESENTATION	
Rea	ad this section, date and sign the form.		
othe this info info time to the or n alre	er person to give Medica or any of its designees of information will be used for underwriting, risk rate or mation collected to third parties without authorized or mation in accordance with applicable law. I understee. I authorize on behalf of Us the use of a Social Seche best of my knowledge and/or belief. I understainly dependent's coverage. I understand that I may ready taken by Medica prior to Medica's receipt of the	any and all records or information per ing, enrollment or eligibility for benef ation and that the individuals enrolled tand that I have the right to review Mer curity Number for the purpose of identi and and agree that any omissions or increvoke this authorization by notifying Nate revocation. If I refuse to sign this authorization to sign this authorization.	hospital, clinic, institution, physician, insurance company, employer of taining to medical history or services rendered to Us. I understand that its. I understand that in certain circumstances Medica may disclose the on or added to this form have the right to see and correct their personal dica's Privacy Notice before signing this form and to request a copy at an dication. The information provided on this form is accurate and complete correct statements knowingly made by Us on this form may invalidate meledica in writing. If I revoke the authorization, it will not affect any action horization, it will affect my dependents' and my eligibility and enrollment mation used or disclosed pursuant to this authorization will remain subject.
	North Dakota and South Dakota residents: For p for 24 months from the date of signature.	urposes of facilitating enrollment, unle	ss revoked, this authorization permits Medica to obtain information abou
	Minnesota residents: For purposes of facilitating nature until termination of our coverage.	enrollment, unless revoked, this autho	rization permits Medica to obtain information about Us from the date of
path eme	hogen* performed on (1) a criminal offender or co ergency medical services personnel* at a hospital c ergency medical services.	rime victim as a result of a crime that or medical care facility; or (3) emergen	test to determine the presence of the HIV antibody or other bloodborn was reported to the police; (2) a patient who received the services of the police; (2) a patient who received the services of the police; (2) a patient who received the services of the police; (3) and the police; (2) a patient who received the services of the police; (3) and the police; (4) and the police; (5) and the police; (6) and the police; (7) and the police; (8) and the police; (9) and the police; (10) and the p
	Wisconsin residents: For purposes of facilitating e date of signature.	inionment, unless revoked, this authori	zation permits Medica to obtain information about Us for 30 months fror
(!)	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:Duluth Office:Fargo Office:Mail Route CP275Suite 512Suite 210401 Carlson Parkway130 W. Superior St.1711 Gold Drive SouthMinnetonka, MN 55305Duluth, MN 55802Fargo, ND 58103

St. Cloud Office Sioux Falls Office:

Suite 160 Suite 200

818 Second Street South 110 South Phillips Avenue Waite Park, MN 56387 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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