DOW-R Dental Insurance

Medica

2023 GROUP WAIVE FORM
Minnesota Healthcare Consortium and DOW-R Dental Insurance

Instructions:

IMPORTANT – PLEASE READ BEFORE COMPLETING

Please read and complete your enrollment/change/cancellation form thoroughly to ensure accurate processing.

- If **waiving Medical/Dental coverage**, complete Sections A and B.

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 or1-800-952-3455 (TTY users, call 711).

Visit us at **Medica.com**.

DOW-R Dental Insurance

Medica

2023 Health Insurance Waive Form

DOW-R Usage Loc#_____
Effective Date_____ Invoice CR D
Date to Medica_____ Month invoice _____
Date to DD _____ #----------

Please type or print clearly.

SECTION A - EMPLOYEE INFORMATION

SECTION

Effective Date: _____				
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]**			
❑ Waive	Street			
	City	State	ZIP Code	
Contact Information [6]				
Cellular/Home Telephone	Work Telephone	Email		
Gender ❑ Male ❑Female	Birth date (mm/dd/yy)	Date of hire (mm/dd/yy)		

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 Please provide each applicant's name as stated on their Social Security card, if they have a Social Security card.
3 Please ensure your full address is filled out, so you can receive important mailings, including your Medica ID card and welcome kit.

SECTION B – 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