DOW-R Dental Insurance

Medica

2024 GROUP ENROLLMENT/CHANGE/CANCELLATION/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.
- For new enrollees, please submit this completed enrollment/change/cancellation/waive form to your employer.
- If you are currently enrolled:
  - If **canceling Medical/Dental coverage**, please complete Sections A, D and G.
  - Only adding a dependent to your existing contract, please include your name in Section A and your dependent's information in all other sections.

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 users, call 711).

Visit us at **Medica.com**.

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2024 Group Enrollment/Change/Cancellation 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: _____ ❑ **Name change only**			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 ❑ Waive	Street			
	City	State	ZIP Code	County
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 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.
7 If waiving coverage, complete only Section A and B.

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

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SECTION C – PRODUCT SELECTION and EFFECTIVE DATE (needed if not during open enrollment)

I understand that I am eligible for coverage through my employer. Check coverage below:

❑ Me (Single) ❑ $2,500 deductible

❑ Me and my dependents (Family) ❑ $5,000 deductible

2. Effective date of coverage if not during open enrollment: _____

3. Special Enrollment

❑ If enrolled because of special enrollment, submit documentation of qualifying event.

❑ List qualifying event: _____ Date of qualifying event: _____

SECTION D - MEMBER INFORMATION

	Check appropriate box	List all members to be covered/canceled/changed. Write name as it is stated on their social security card. First name[4] M.I.[4] Last name[4]	Gender	Birth Date (mm/dd/ yy)	Relationship[2]	Dependent's SSN[1]
1	❑ Enroll ❑ Cancel ❑ Change		❑ M ❑ F			
2	❑ Enroll ❑ Cancel ❑ Change		❑ M ❑ F			
3	❑ Enroll ❑ Cancel ❑ Change		❑ M ❑ F			
4	❑ Enroll ❑ Cancel ❑ Change		❑ M ❑ F			
5	❑ Enroll ❑ Cancel ❑ Change		❑ M ❑ F			

If more than 4 dependents, complete a second page 3 Section D for them.

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 **Note:** if your other policy ends at the start of this policy, do not complete.

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. Use extra paper as necessary.

Date of Coverage	Name of Insurance Company	Names of all members covered
Start: End:		
Start: End:		
Start: End:		

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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

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/Delta Dental/Delta Dental or any of its designees any and all records or information pertaining to Medica/Delta Dental 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/Delta Dental 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/Delta Dental'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/Delta Dental in writing.

If I revoke the authorization, it will not affect any actions already taken by Medica/Delta Dental prior to Medica/Delta Dental'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/Delta Dental's privacy standards.

For North Dakota and South Dakota residents: For purposes of facilitating enrollment, unless revoked, this authorization permits Medica/Delta Dental 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/Delta Dental 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 Medica/Delta Dental services personnel* at a hospital or Medica/Delta Dental care facility; or (3) emergency Medica/Delta Dental services personnel who were tested as a result of performing emergency Medica/Delta Dental services.

For Wisconsin residents: For purposes of facilitating enrollment, unless revoked, this authorization permits Medica/Delta Dental to obtain information about Us for 30 months from the date of signature.

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: _____