

Small Employer Group Application (2-50 Employees)

Requirements:

- Group Application completed by employer shall disclose all pertinent information.
- Group size is an average of two to 50 eligible employees, each working a minimum of 20 hours per week in prior calendar year.
- A minimum of 75 percent of eligible employees shall be enrolled under the contract. Employees may waive coverage if covered under another group plan; these waivers will not count against the minimum participation level.
- The employer must contribute a minimum of 50 percent towards the employee's monthly premium rate for Health and Dental coverage; 100 percent for Life and AD&D coverage.

Note: The final rate determination will be based on the evaluation of the group's health history as well as each enrolled person's age at the time of enrollment.

Checklist:

- Medica Health Plans Small Employer Group Application form fully completed and signed by employer and broker.
- Small Group Enrollment Forms completed and signed by all eligible applicants:
 - including newly hired employees in their waiting period
 - former employees on State Continuation or COBRA (including those in the State Continuation or COBRA eligibility period)
 - any covered retirees
 - Waiver of Coverage (Section D) must be completed for employees and/or spouses waiving coverage
- A copy of the most recent billing statement from the current carrier.
- Wage/tax and/or other tax documentation is required for all groups.

Underwriting will request additional information as deemed necessary.

A check made payable to Medica Health Plans for the estimated first month's group premium based on preliminary rates quoted. (Check will not be cashed unless the group has been accepted by Medica underwriting and the group confirms acceptance.)

Please send all completed new groups to the **Medica Sales Department** at:

Mail Route CP286
PO Box 9310
Minneapolis, MN 55440-9310

Small Employer Group Application (2-50 Employees)

MEDICA®

A. EMPLOYER INFORMATION

1. Company Name (Incl. dba)		Federal Tax I.D. #			
2. Address	Street or P.O. Box	City	State	County	Zip Code
3. Billing Address (if different than above)					
4. Contact Person		5. Type of Ownership: <input type="checkbox"/> Proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> Non-Profit <input type="checkbox"/> C Corp <input type="checkbox"/> S Corp <input type="checkbox"/> LLC			
6. Phone Number and Extension ()		7. Fax Number ()			
8. Nature of Business		9. SIC (Industry Code)		10. Date Business Began	
11. Current Group Carrier (<i>A copy of your most current Group bill must be submitted</i>)					
12. Have you had Coverage with Medica before? <input type="checkbox"/> Yes <input type="checkbox"/> No (<i>If yes, under what company name?</i>)					Medica Group Number
13. If prior group dental coverage, list type of plan, name of carrier, and length of coverage.				14. Email Address	

B. EMPLOYER REPRESENTATION – PLEASE READ CAREFULLY

- The employer understands and agrees that, (1) no coverage will become effective until the date specified by Medica after this application has been approved, (2) the information provided in this application is complete and true to the best of my knowledge and is the basis for the coverage to be issued, and that material misrepresentations of facts could result in termination of coverage, (3) applications for each eligible employee and dependent must receive prior approval by Medica before coverage becomes effective, and (4) no coverage will be effective until the first monthly premium has been paid in full.
- The employer agrees that any deposit is refundable and will be applied to the first monthly premium due if this application is approved. If this application is not approved, the full deposit will be refunded.
- The employer agrees to allow Medica to review any of the employer's records that Medica deems necessary to approve this application.
- It is also agreed that no agent can approve this application, set an effective date, or waive or alter any provision of this application or any contracts issued.
- It is agreed that the employer will remit monthly charges for all covered employees and that failure to remit the required changes by the due date may result in termination of coverage.

Employer Signature **X** _____ Date _____
(Owner or Officer)

C. AGENT/REPRESENTATIVE INFORMATION

Agent Signature X	Agent Name	Date Signed	Agent Number
Address	Phone Number ()	Fax Number ()	
Sales Representative Name			

D. ADDITIONAL ELIGIBILITY INFORMATION

- If you were in business last year, how many individuals did you employ, on average, working a minimum of 20 hours per week during **the preceding calendar year**? _____
- If you are a new business, how many individuals are reasonably expected to be employed in the current calendar year? _____
- Does your company have common ownership/control in or with any other company? Yes No
If yes, please list name of company(s) and total number of employees, owners and partners.

Name of Company(s)	Address	Number of Employees, Owners & Partners
_____	_____	_____
- Does your company have a contract with a Professional Employee Organization (PEO)? Yes No
If yes, list which PEO Firm (a current contract must be submitted); and specify how many of these employees are applying for coverage.

- Please list any employees that may be residing out of area in other states.

- How many eligible employees or dependents are disabled or out on a leave of absence for any reason? *Please list names.*

- Requested effective date. ____/____/____
 Please allow adequate time for processing. **Employer should not cancel existing coverage until employer receives Medica's written notice of approval of this application.**
 _____ **A. Total** number of employees, including new hires in waiting period, all part-time, owners, partners and those working outside of Minnesota.
 _____ **B.** How many hours per week does an employee have to work to be considered eligible for coverage?
 _____ **C.** Which classifications of employees are eligible for coverage? (i.e., all full time employees, non-union, etc.)
 _____ **D. Total** eligible employees (including new hires in their waiting period) that are **applying for coverage.**
 _____ **E. Total** eligible employees that are **waiving coverage.**
 _____ **F. Total** number of individuals covered under State Continuation/COBRA.
 _____ **G. Total ineligible** employees (including 1099's and seasonal working less than 9 months a year).
- New hire coverage begins:
 Date of Hire Completion of waiting period First of the month after completion of waiting period
 Waiting period: N/A 30 days 60 days 90 days Other _____
- Employer Contribution Amount:

	Health	Dental	Life/AD&D
Employee: (Minimum 50% Health and Dental 100% Life/AD&D)	_____ %	_____ %	_____ %
Dependent:	_____ %	_____ %	_____ %

E. BENEFIT SELECTION – PLEASE INDICATE THE DESIRED PRODUCT(S)

Which Medica Benefit Plan(s) are selecting? _____ Elect Choice MIC Essential
 Life Insurance* Life/AD&D \$ _____ Dependent Life

Dental Insurance**

Metro Dental Preventive: High Standard **Comprehensive:** High Standard **Ortho** Yes No
Regional Dental Preventive: **Dental Explorer:** Option I Option II Option III **Ortho** Yes No

* (Administered and Underwritten by United HealthCare Insurance Company)

** (Administered and Underwritten by Delta Dental Plan of Minnesota)

SUMMARY OF MEDICA'S PRIVACY PRACTICES

Effective June 11, 2003

There are several state and federal laws requiring Medica to protect our members' personal information. The most recent regulations (45 CFR parts 160 and 164) are tied to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These regulations require health plans such as Medica to provide you with information about how your personal information may be used and disclosed. The regulations describe how Medica may use and disclose this information and how you can access your personal information. Medica must adhere to the terms of its privacy notice. Medica may change or amend its privacy notice; however, if it's materially changed, Medica will issue you a revised privacy notice within sixty (60) days from the date it is amended.

The law permits Medica to use and disclose your personal information for purposes of treatment, payment, and health care operations without first obtaining your authorization. There are other limited circumstances in which Medica may use and disclose your personal information without your authorization such as public health, regulatory, and law enforcement activities. Whether personal information is used or disclosed with or without authorization, Medica uses or discloses personal information only to those persons who need to know and only the minimum amount necessary to perform the required activity.

The law also gives you rights to access, copy, and amend your personal information. You have the right to request restrictions on certain uses and disclosures of your personal information. You also have the right to obtain information about how and when your personal information has been used and disclosed.

These duties, responsibilities, and rights are described in more detail in Medica's Privacy Notice.

Please Note: Medica's Privacy Notice does not apply to members whose employers are self-insured. If your employer is self-insured, you need to contact your employer for more information about your health plan's privacy practices.

MEDICA'S PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THIS NOTICE IS INTENDED FOR MEDICA INSURANCE COMPANY, MEDICA HEALTH PLANS, AND MEDICA HEALTH PLANS OF WISCONSIN MEMBERS (COLLECTIVELY REFERRED TO AS "MEDICA"). IF YOU ARE A COVERED PERSON IN A SELF-INSURED GROUP HEALTH PLAN, YOU HAVE A RIGHT TO RECEIVE A PRIVACY NOTICE DIRECTLY FROM YOUR GROUP HEALTH PLAN.

Medica is committed to protecting and maintaining the privacy and confidentiality of your personal information. This notice describes our privacy practices and our related legal duties. It also describes your rights relating to personal information about you.

What is personal information?

As a health plan, Medica obtains, maintains, uses and discloses information about our members such as name, address, telephone number, Social Security number, age, date of birth, gender, marital status, dependent information, and health history. In addition, Medica obtains and generates information about our members' enrollment, physical and mental health conditions, prior approval for services, referrals, coverage determinations, claims data, medical records, and payment for health care services. This and any other information that individually identifies you is called "personal information."

How does Medica protect your personal information?

Medica takes its responsibility of protecting your personal information seriously. Where possible, Medica de-identifies or encrypts personal information. We use and disclose personal information only to the extent necessary to conduct treatment, payment and health care operations, or to comply with legal, regulatory or accreditation requirements. Medica uses and discloses only the minimum amount of personal information necessary to perform the required activity. In addition to physical and technological safeguards, Medica has adopted administrative policies and procedures that require its employees, business associates and health care providers to treat personal information as private. Medica provides training in privacy procedures to its employees. We protect the personal information of applicants and former members just as we protect the personal information of current Medica members.

Under what circumstances does Medica use or disclose personal information?

Medica and its business associates obtain, maintain, use and share personal information to carry out certain routine activities. Routine activities include: (i) treatment-related activities, such as referring you to a doctor or other provider; (ii) payment-related activities, such as paying a claim for medical services rendered; and (iii) health care operations, such as professional peer review. Other examples of routine activities include:

- Enrollment and eligibility, benefits management, and utilization management
- Customer service
- Coordination of care
- Health improvement and disease management (for example, sending information on treatment alternatives or other health-related benefits)
- Premium billing and claims administration
- Complaints and appeals
- Underwriting, actuarial studies, and premium rating
- Regulatory and accreditation oversight, and legal compliance
- Credentialing and quality assessment
- Business planning or management and general administrative activities (for example, employee training and supervision, legal consultation, accounting, auditing)
- Anti-fraud activities

With whom does Medica share personal information?

Medica shares personal information for routine activities with health care providers, accrediting organizations, regulatory agencies, law enforcement, group policyholders, and our business associates, who are under contract to provide services to or on behalf of Medica (for example, claims processing services).

There are also other activities for which Medica uses or discloses your personal information without authorization, as permitted by law. These activities include:

- public health activities (such as disease intervention);
- health care oversight activities required by law or regulation (such as professional licensing, member satisfaction surveys, quality surveys, or insurance regulation);
- law enforcement purposes (such as fraud prevention); and
- assisting in the avoidance of a serious and imminent threat to health or safety.

Medica has policies that limit the disclosure of personal information to employers. However, Medica must share some personal information (for example, enrollment information) with a group policyholder or its designee to administer its business. The group policyholder or designee is responsible to safeguard the personal information from being used for purposes other than administering health plan benefits.

Medica may occasionally contact you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Under what circumstances can you authorize Medica to use and disclose your personal information?

From time to time, Medica is interested in using or disclosing personal information for purposes other than treatment, payment, health care operations, or as required by law. In these situations, Medica is required to obtain your written authorization. Medica will not be able to release the particular personal information until we have obtained your authorization. You have the right to decide not to authorize Medica to use or disclose your personal health information in these situations. You will not encounter any adverse consequences if you elect not to authorize a particular activity. You, or your authorized representative (such as a power of attorney or court-appointed guardian), may revoke an authorization that has been given in the past, except to the extent that Medica has already relied and acted on your permission.

What are your rights to your personal information?

You have the following rights with regard to the personal information that Medica has about you. You, or your personal representative on your behalf, may:

Request restrictions of disclosure. You have the right to ask Medica to limit how it uses and discloses personal information about you. Your request must be in writing and be specific as to the restriction requested and to whom it applies. Even though you ask, Medica is not required to agree to such restrictions. If we do honor your request, Medica agrees not to use or disclose your personal information as you requested except in emergency situations in which you require treatment. To exercise this right, please contact Customer Service at the telephone number on the back of your identification card, or contact us at PO Box 9310, Minneapolis, MN 55440-9310.

Request receipt of confidential communications. You have the right to ask us to communicate with you about confidential matters by alternative means or at alternative locations. Medica will accommodate reasonable requests, but the requests must be in writing and you must clearly state that the disclosure of all or part of the personal information could endanger you. An example of alternative communications would include a request to contact you at a certain telephone number or to use an address that is different than the one in our files. To exercise this right, please contact Customer Service at the telephone number on the back of your identification card, or contact us at PO Box 9310, Minneapolis, MN 55440-9310.

Inspect or obtain a copy of your personal information. In order to administer its health plans, Medica stores members' personal information in a designated record set. You have the right to inspect and obtain a copy of the personal information you are entitled to under the law. For example, certain personal information, such as psychotherapy notes, cannot be inspected or copied. Your request must be in writing and on Medica's authorization form. Your request will be honored, to the extent possible, within thirty (30) days of receipt. Medica may impose a reasonable charge for providing copies of personal information. To exercise this right, please contact Customer Service at the telephone number on the back of your identification card, or contact us at PO Box 9310, Minneapolis, MN 55440-9310.

Request an amendment or deletion. You have the right to submit a written request to amend personal information about you in Medica's designated record set that you believe is wrong or incomplete. Medica will act on your request within thirty (30) days of receipt. Medica is not obligated to honor your request. If Medica disagrees, you may file a written statement of disagreement. Medica may prepare a rebuttal. If it does, Medica will provide you with a copy of the rebuttal. Your request, statement of disagreement and rebuttal will be maintained in Medica's designated record set. To exercise this right, please contact Customer Service at the telephone number on the back of your identification card, or contact us at PO Box 9310, Minneapolis, MN 55440-9310.

Request an accounting of disclosures. You have the right to receive an accounting or listing of disclosures Medica has made of your personal information subject to certain exceptions. Your request for an accounting cannot go back more than six years from the date the request was made (but not before April 14, 2003). To exercise this right, please contact Customer Service at the telephone number on the back of your identification card, or contact us at PO Box 9310, Minneapolis, MN 55440-9310.

Request a copy of this notice. You may ask for and obtain a separate paper copy of this notice. To exercise this right or for questions about this notice, please contact Customer Service at the telephone number on the back of your identification card, or contact us at PO Box 9310, Minneapolis, MN 55440-9310.

Right to complain about Medica's privacy practices. If you feel your privacy rights have been violated, you may file a complaint. You will not be retaliated against for filing a complaint. To file a complaint with Medica, please contact Customer Service at the telephone numbers and address listed above. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. To do so, write to the Office for Civil Rights, U.S. Department of Health & Human Services, 233 N. Michigan Ave. Suite 240, Chicago, IL 60601.

About this notice.

Medica is required by law to maintain the privacy of personal information and to provide this notice. We reserve the right to change the terms of our notice and to make the new notice effective for all personal information that we maintain. If we make such a change, we will send you a revised notice by mail or electronically. By law, Medica must abide by the terms of the privacy notice currently in effect. This notice is effective June 11, 2003.

As used in this notice, "Medica" refers to the family of health plan businesses that includes Medica Health Plans, Medica Health Plans of Wisconsin and Medica Insurance Company. This notice is provided to subscribers enrolled in fully-insured Medica products, for the benefit of themselves and their dependents.