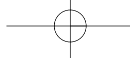

MEMBER ENROLLMENT FORM

P.O. Box 59052
Minneapolis, MN 55459-0052
(763) 847-4488 1-800-379-7727

SHADED AREAS TO BE COMPLETED BY EMPLOYER

EMPLOYEE – COMPLETE ALL UNSHADED AREAS.

NAME OF EMPLOYER	GROUP NUMBER	CLASS	NETWORK	SUB-GROUP	PRODUCT

☐ New Hire ☐ Rehire/return ☐ Late Enrollment ☐ Retiree ☐ MN Cov. (COBRA) (Begin Date)
☐ Open Enrollment ☐ Early Retiree
☐ Special Enrollment: Date ______
☐ Termination/reduction in work hours ☐ Employer contribution terminated ☐ Divorce/legal separation ☐ Death ☐ Birth/adoption ☐ Marriage

QUALIFYING EVENT | Hrs. worked per week | Date of Full-Time Employment (Month / Day / Year) | Coverage Effective Date (Month / Day / Year)

SIGNATURE OF EMPLOYER **X** ______ Date Signed: Month / Day / Year

EMPLOYEE'S LAST NAME (LEGAL NAME)	FIRST NAME	M.I.	DATE OF BIRTH Month / Day / Year	SOCIAL SECURITY NUMBER

STREET ADDRESS/APT. NO.	CITY	STATE	ZIP

EMPLOYEE'S TELEPHONE	E-MAIL ADDRESS		MARITAL STATUS
HOME ( ) BUSINESS ( )		☐ MALE ☐ FEMALE	☐ SINGLE ☐ MARRIED

Do you or any family members listed below have other coverage **in addition to** this plan? ☐ NO ☐ YES - **Type:** ☐ Medical ☐ Dental

If yes, name(s) ______ ☐ Single coverage or ☐ Family coverage

Name of insurance company ______

Are you covered by or eligible for Medicare Part A or B? ☐ NO ☐ YES – *(Attach a copy of Medicare card)* Effect. date: Part A ______ Part B ______

Are you covered by Medicare Part D? ☐ NO ☐ YES - effective date of Part D ______

Is your spouse and/or dependent covered by or eligible for Medicare Part A or B? ☐ NO ☐ YES – *(Attach a copy of Medicare card)* Effect. date: Part A ______ Part B ______

Is your spouse and/or dependent covered by Medicare Part D? ☐ NO ☐ YES - effective date of Part D ______

☐ I ACCEPT COVERAGE FOR: ☐ **Medical:** ☐ Self ☐ Spouse ☐ Children ☐ **Dental:** ☐ Self ☐ Spouse ☐ Children

FILL IN THE FOLLOWING INFORMATION FOR EACH ELIGIBLE DEPENDENT TO BE COVERED

LAST NAME ONLY IF DIFFERENT FROM ABOVE	FIRST NAME	MIDDLE INITIAL	RELATIONSHIP	SEX (M or F)	DATE OF BIRTH Month	Day	Year	SOCIAL SECURITY NO.

Do all of the dependent(s) listed above reside at the same address as the employee? ☐ YES ☐ NO

If no, list dependent(s) name and address ______

If last name is different for dependents, please explain why ______

Are any of the above listed dependent(s) age 19 or older, students? ☐ YES ☐ NO

If yes, please indicate the name, school attending and status

NAME	SCHOOL	STATUS	
______	______	☐ Part-Time	☐ Full-Time
______	______	☐ Part-Time	☐ Full-Time

Are any age 19 or older dependents listed above incapable of self-sustaining employment because of physical or mental handicap and dependent on the employee for a majority of their financial support? ☐ YES ☐ NO. If YES, date of onset of physical or mental handicap ______

If yes, please provide supporting documentation.

☐ I DECLINE COVERAGE ☐ Medical ☐ Dental DUE TO: ☐ Other coverage ☐ Other reason ______

If you are declining major medical expense coverage for yourself or your dependents (including your spouse) because of other medical insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request coverage within 31 days after you or your dependent's other coverage ends or the employer stops contributing to the coverage. In addition, 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 new dependent and spouse, provided that you request enrollment within 31 days after marriage, birth, adoption, or placement for adoption.

I freely and voluntarily decline coverage as indicated above.

Date: ______ Employee Signature (if declining coverage): ______

I represent that the answers to the questions and statements made on this form are true and complete.

On behalf of myself and my enrolled dependents, I authorize any physician, medical practitioner, hospital, clinic, veterans' administration facility, or other medically related facility who has treated me and/or my dependents enrolled on this form, to release to PreferredOne Administrative Services, Inc. (acting for and on behalf of its self-funded plan clients or it's affiliates PreferredOne Community Health Plan or PreferredOne Insurance Company) information as to diagnosis, treatment, and prognosis with respect to any physical or mental conditions of me (or, if requested, my enrolled dependents) for insurance underwriting and plan administration purposes. This authorization excludes the release of information about HIV (AIDS virus) tests which were administered: (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; 2) to a patient who received the services of emergency medical personnel at a hospital or medical facility; or 3) to emergency medical personnel who were tested as a result of performing emergency medical services. This authorization also excludes psychotherapy notes.

This authorization shall remain valid as long as I am continually covered by the medical and/or dental coverage in which I am enrolling with this form. I agree that a copy of this authorization shall be valid as the original. Information released pursuant to this authorization is released to an entity subject to the Health Insurance Portability and Accountability Act (HIPAA). This authorization may be revoked by submitting a written revocation to PreferredOne Customer Service. Such revocation will not effect actions taken prior to the revocation. Because this authorization is for underwriting, risk rating, and enrollment purposes, revocation of this authorization or failure to give this authorization may result in denial or termination of coverage.

I understand that I must update this form and resubmit it if anything changes that affects the information on this form between submission of the form and effective date of coverage. **I understand that providing false information or omission of relevant information on this form may result in denial of claims, cancellation of coverage, or an increase in premiums, and may be considered insurance fraud.** I understand that, subject to the terms and conditions of the certificate of coverage or plan under which I am enrolling for coverage, I may be subject to a pre-existing condition limitation.

SIGNATURE OF EMPLOYEE *(required)* (if applying for coverage) **X** ______ Date Signed: Month / Day / Year