

SHADED AREAS TO BE COMPLETED BY EMPLOYER

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NAME OF EMPLOYER		GROUP NUMBER	CLASS	SUB-GROUP	PRODUCT
<input type="checkbox"/> New Hire	<input type="checkbox"/> Late Enrollment	<input type="checkbox"/> MN Cov. (COBRA) (Begin Date)	QUALIFYING EVENT	HRS. WORKED PER WEEK	Date of Full-Time Employment Month Day Year
<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Special Enrollment				Coverage Effective Date Month Day Year
SIGNATURE OF EMPLOYER X					Month Date Signed 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
HEIGHT		WEIGHT		
EMPLOYEE'S TELEPHONE HOME () BUSINESS ()	E-MAIL ADDRESS		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED

Do you or any family members listed below have other coverage **in addition to** this plan? NO YES
 If yes, name(s) _____ Single coverage or Family coverage
 Name of insurance company _____

Are you covered by or eligible for Medicare Part A and/or Part B:? NO YES - (Attach a copy of Medicare card) Effect. date: Part A _____ Part B _____

Is your spouse covered by or eligible for Medicare Part A and/or Part B:? NO YES - (Attach a copy of Medicare card) Eff. date: Part A _____ Part B _____

Do you or any family member included on this enrollment form currently have or have you had continuous health coverage for the last 12 months (18 months for late enrollees)? NO YES - please list carrier name, effective date and termination date _____

Have you ever been previously covered by **PreferredOne Community Health Plan (PCHP)**? YES NO
 If yes, what name(s) did you use? _____

I ACCEPT COVERAGE FOR: Self Spouse Children

FILL IN THE FOLLOWING INFORMATION FOR EACH PERSON TO BE COVERED

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

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
_____	_____	<input type="checkbox"/> Part-Time <input type="checkbox"/> Full-Time
_____	_____	<input type="checkbox"/> Part-Time <input type="checkbox"/> Full-Time

EMPLOYEE - COMPLETE ALL UNSHADED AREAS.

HEALTH INFORMATION: For confidentiality, the answers to these questions do not appear on the Employer copy.

1. Have you or any family member eligible for coverage EVER been treated for, or diagnosed with, any of the following conditions? YES (please list details below) NO

If YES, please check all that apply.

- | | | | | |
|---|---|--|---|---|
| <input type="checkbox"/> alcohol use | <input type="checkbox"/> blood disorder | <input type="checkbox"/> drug use | <input type="checkbox"/> heart or circulatory disorder | <input type="checkbox"/> psychological or neurological disorder |
| <input type="checkbox"/> allergies | <input type="checkbox"/> cancer | <input type="checkbox"/> DWI/DUI | <input type="checkbox"/> immune system disorder | <input type="checkbox"/> reproduction system disorder |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> counseling services | <input type="checkbox"/> eating disorder | <input type="checkbox"/> kidney or urinary tract disorder | <input type="checkbox"/> respiratory disorder |
| <input type="checkbox"/> asthma | <input type="checkbox"/> diabetes | <input type="checkbox"/> eye or ear disorder | <input type="checkbox"/> liver disorder | <input type="checkbox"/> seizure/epilepsy |
| <input type="checkbox"/> back disorder | <input type="checkbox"/> digestive or intestinal disorder | <input type="checkbox"/> headache/migraine | <input type="checkbox"/> muscle, bone or joint disorder | <input type="checkbox"/> stroke |
| <input type="checkbox"/> currently have a condition that may require medical, surgical or hospital care (explain) | | | <input type="checkbox"/> thyroid disorder | |
| <input type="checkbox"/> been hospitalized or had surgery for any condition or injury (explain) | | | | |

IF YOU HAVE CHECKED ANY BOX ABOVE, PLEASE EXPLAIN WITH DETAILS BELOW:

PERSON'S NAME	DIAGNOSIS AND DETAILS ABOUT CONDITION, TREATMENT	DATE OF DIAGNOSIS	DATE OF RECOVERY	DAYS IN HOSPITAL

Is anyone currently pregnant? Yes No If YES, please list the due date, describe any complications experienced or if multiple births are expected.

2. MEDICATIONS: For each person eligible for coverage, complete the following (List ALL PAST and PRESENT medications used):

PERSON'S NAME	MEDICATION	REASON PRESCRIBED	DOSAGE (mg / gm)	# PER DAY	REFILLS PER YEAR	STILL PRESCRIBED?
						<input type="checkbox"/> yes <input type="checkbox"/> no
						<input type="checkbox"/> yes <input type="checkbox"/> no
						<input type="checkbox"/> yes <input type="checkbox"/> no
						<input type="checkbox"/> yes <input type="checkbox"/> no

I DECLINE COVERAGE FOR: Self Spouse Children

I am NOT applying for coverage because of: Spouse's Group Plan Medicare Group Coverage Continuation

Individual Policy Medical Assistance MCHA Cost Other _____

I freely and voluntarily decline health coverage through PCHP.

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 your other coverage ends. 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 dependents, provided that you request enrollment within 31 days after marriage, birth, adoption, or placement for adoption.

Date: _____ Employee Signature (If declining coverage): _____

I represent that the answers to the questions and statements made on this form are true and complete. If my answers are incorrect or untrue, PCHP has the right to reduce or deny benefits or rescind coverage.

I authorize any physician, medical practitioner, hospital, clinic, veterans administration facility, or other medically related facility, insurance or reinsurance company having information available as to diagnosis, treatment and prognosis with respect to any physical or mental conditions and/or treatment of me or my covered dependents to give to PCHP any and all of the information requested. 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.

I agree that a photographic copy of this authorization shall be as valid as the original. I agree that this authorization shall be valid for 26 months from the date shown below.

I understand, subject to the terms and conditions of PCHP, that PCHP reserves the right to impose a preexisting condition limitation, subject to credit given for prior continuous qualifying coverage.

I UNDERSTAND THAT PROVIDING FALSE INFORMATION OR OMISSION OF RELEVANT INFORMATION IN THIS APPLICATION MAY RESULT IN THE DENIAL OF CLAIM(S) OR CANCELLATION OF COVERAGE.

IF APPLYING FOR COVERAGE

SIGNATURE OF EMPLOYEE (required) **X** _____

Date Signed
Month Day Year