MEMBER ENROLLMENT FORM

PLEASE KEEP A COPY OF THIS FORM FOR YOUR RECORDS

PreferredOne®

PREFERREDONE INSURANCE COMPANY
PREFERREDONE COMMUNITY HEALTH PLAN

PreferredOne®
PreferredOne Insurance Company
PreferredOne Community Health Plan

MEMBER ENROLLMENT FORM

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

Please use black or blue ink only. Do not highlight any areas on this form.

EMPLOYER COMPLETE

☐ PIC ☐ PCHP	NAME OF EMPLOYER	GROUP NUMBER	CLASS	NETWORK	SUB-GROUP	PRODUCT

☐ New Hire
☐ Late Enrollment
☐ Open Enrollment
☐ MN Continuation (COBRA)
(begin date) _____
☐ Early Retiree
☐ Retiree

Special Enrollment: *(date)* _____
☐ Termination/Reduction in Work Hours ☐ Employer Contributions Terminated
☐ Divorce/Legal Separation ☐ Death ☐ Birth ☐ Adoption/Placement for Adoption*
☐ Marriage ☐ COBRA Exhaustion ☐ Qualified Medical Child Support Order*
☐ Children Health Insurance Program (CHIP)
☐ Other. Reason _____ (** provide legal documentation)*

QUALIFYING EVENT	HOURS 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 COMPLETE

EMPLOYEE'S LAST NAME (LEGAL NAME)	FIRST NAME	M.I.	DATE OF BIRTH	SOCIAL SECURITY NUMBER *(Required for Mandatory Federal Reporting)*

STREET ADDRESS / APT. NO. CITY STATE ZIP

EMPLOYEE'S TELEPHONE
HOME ( ) BUSINESS ( )

E-MAIL ADDRESS

☐ 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, B or D? ☐ NO ☐ YES

If YES *(attach a copy of Medicare card)* effective date: Part A _____ Part B _____ Part D _____

Is your spouse and/or dependent covered by or eligible for Medicare Part A, B or D? ☐ NO ☐ YES

If YES *(attach a copy of Medicare card)* effective date: Part A _____ Part B _____ Part D _____

Have you ever been covered by **PreferredOne Community Health Plan** (PCHP)? ☐ NO ☐ YES or **PreferredOne Insurance Company** (PIC)? ☐ NO ☐ YES

If YES, what name(s) did you use? _____

☐ **I ACCEPT COVERAGE FOR:** ☐ **Medical:** ☐ Self ☐ Spouse ☐ Children *(to age 26 or disabled. If disabled, see below)*
☐ **Dental:** ☐ Self ☐ Spouse ☐ Children *(to age 19 or disabled. If disabled, see below)*

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

LAST NAME ONLY IF DIFFERENT FROM ABOVE	FIRST NAME	M.I.	RELATION-SHIP	SEX M F	DATE OF BIRTH month day year	SOC. SECURITY NO. *(Required for Mandatory Federal Reporting)*

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 age 26 or older dependents listed above incapacitated and incapable of self-sustaining employment because of physical or mental disability and dependent on the employee for a majority of their financial support? ☐ NO ☐ YES

If YES, list dependent(s) and date of onset of physical or mental disability and please provide supporting documentation as proof of incapacity.

_____

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FOR USE WITH SELF-INSURED DENTAL COVERAGE ONLY

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

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

NAME _____ SCHOOL _____ ☐ Part-time ☐ Full-time

NAME _____ SCHOOL _____ ☐ Part-time ☐ Full-time

PreferredOne Insurance Company (PIC) and PreferredOne Community Health Plan (PCHP) comply with the Minnesota Insurance Fair Information Reporting Act. In compliance with this law, this notice is to inform the applicant that during the health underwriting process personal information about the applicant may be collected from persons other than the applicant. The information collected by PIC or PCHP or the insurance broker may, in certain circumstances, be disclosed for health underwriting purposes to third parties without authorization of the applicant, but only if permitted by applicable state and federal privacy laws. The applicant has a right to see the personal information collected about the applicant in the health underwriting process, and there is a procedure by which the applicant may correct inaccurate personal information collected. For further information about these rights, contact the PIC and PCHP customer service area. I agree on behalf of myself, my spouse and my dependent applicants to execute and submit all authorizations and releases required by any insurer, Medicare or Medicaid program, pharmacy, health benefit plan manager or administrator, physician, medical practitioner, hospital, clinic, veterans' administration facility, any third-party database provider, any medically related organization or entity, PIC, PCHP and PreferredOne Administrative Services, Inc. (PAS), who has treated or has claim history (other than claim history that PAS obtained acting in its capacity as a preferred provider organization) or has medical information about me, my spouse, and/or my dependent applicants, to release to PIC or PCHP information as to diagnosis, treatment, and prognosis with respect to any physical or mental conditions of me (or, if requested, my dependent applicants) for insurance underwriting and plan administration purposes. These authorizations exclude 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 shall remain valid as long as I am/we are continually covered by the medical and/or dental plan in which I am/we are enrolling with this form. I/we 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 the Customer Service Department of PIC or PCHP but will not affect actions taken prior to the revocation. I/we understand that I must update this form and resubmit it to the Customer Service Department of PIC or PCHP if anything changes that affects information on this form between submission of the form and the effective date of coverage. **I/we understand that providing false information or intentional misrepresentation of 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/we understand that subject to the terms and conditions of the certificate of coverage or plan under which I am/we are enrolling for coverage. Persons age 19 and over eligible for coverage may be subject to a pre-existing condition limitation of 12 months (18 months if a late enrollee) for services received or recommended during the 6-month period prior to enrollment date if a certification of prior coverage is not provided or is not sufficient to reduce duration of the limitation period. You can request a certification from your prior plan or issuer. PIC or PCHP can also help you obtain the certification by calling the Customer Service telephone number. If it is determined during the first two years after the effective date of your coverage that you misstated your age or the age of any enrolled dependent and if the right age had been provided, the individual would not have been eligible for coverage, then PIC or PCHP will refund all premiums paid for that individual from their effective date of coverage within 90 days of the date of discovery of the misstatement and in all other cases PIC or PCHP will adjust premium. PIC or PCHP will seek reimbursement for claims paid from the individual's effective date of coverage.

IF APPLYING FOR COVERAGE

SIGNATURE OF EMPLOYEE *(required)* **X** _____ DATE SIGNED _____ month / day / year

If you are declining major medical expense coverage for yourself or your dependents (including your spouse) because of other medical coverage, complete the box below.

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

I am **NOT** applying for coverage because of: ☐ Spouse's Group Plan ☐ Medicare ☐ Group Coverage Continuation ☐ MNCare ☐ Individual Policy ☐ Medical Assistance ☐ MCHA ☐ Cost ☐ Other reason _____

I freely and voluntarily decline coverage as indicated above.

_____ Date _____ Employee Signature (If declining coverage)

NOTE: You and your dependents in the future may be eligible to enroll in this plan, provided that you request coverage within 31 days after other coverage ends or the employer stops contributing to your 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 spouse, along with your new dependent, provided that you request enrollment within 31 days after marriage and a covered employee may, at any time, enroll his/her newborn dependent child acquired as a result of birth, newly adopted dependent child or dependent child newly placed with the employee for adoption, provided that the employee is previously enrolled for coverage.

APPLIES ONLY TO PREFERREDONE INSURANCE COMPANY PLANS.

PreferredOne Insurance Company
6105 Golden Hills Drive
Golden Valley, MN 55416
763.847.4477 1.800.997.1750

NOTICE CONCERNING POLICYHOLDER RIGHTS IN AN INSOLVENCY UNDER THE MINNESOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION LAW.

If the insurer that issued your life, annuity, or health insurance policy becomes impaired or insolvent, you are entitled to compensation for your policy from the assets of that insurer. The amount you recover will depend on the financial condition of the insurer.

In addition, residents of Minnesota who purchase life insurance, annuities, or health insurance from insurance companies authorized to do business in Minnesota are protected, SUBJECT TO LIMITS AND EXCLUSIONS, in the event the insurer becomes financially impaired or insolvent. This protection is provided by the Minnesota Life and Health Insurance Guaranty Association.

Minnesota Life and Health Insurance Guaranty Association
4760 White Bear Parkway Suite 101
White Bear Lake, MN 55110
Phone Number: 651.407.3149 Fax Number: 651.407.3150

The maximum amount the guaranty association will pay for all policies issued on one life by the same insurer is limited to $500,000. Subject to this $500,000 limit, the guaranty association will pay up to $500,000 in life insurance death benefits, $130,000 in net cash surrender and net cash withdrawal values for life insurance, $500,000 in health insurance benefits, including any net cash surrender and net cash withdrawal values, $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values, $410,000 in present value of annuity benefits for annuities which are part of a structured settlement or for annuities in regard to which periodic annuity benefits, for a period of not less than the annuitant's lifetime or for a period certain of not less than ten years, have begun to be paid on or before the date of impairment or insolvency, or if no coverage limit has been specified for a covered policy or benefit, the coverage limit shall be $500,000 in present value. Unallocated annuity contracts issued to retirement plans, other than defined benefit plans, established under section 401, 403(b), or 457 of the Internal Revenue Code of 1986, as amended through December 31, 1992, are covered up to $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values, for Minnesota residents covered by the plan provided, however, that the association shall not be responsible for more than $10,000,000 in claims from all Minnesota residents covered by the plan. If total claims exceed $10,000,000, the $10,000,000 shall be prorated among all claimants. These are the maximum claim amounts. Coverage by the guaranty association is also subject to other substantial limitations and exclusions and requires continued residency in Minnesota. If your claim exceeds the guaranty association's limits, you may still recover a part or all of that amount from the proceeds of the liquidation of the insolvent insurer, if any exist. Funds to pay claims may not be immediately available. The guaranty association assesses insurers licensed to sell life and health insurance in Minnesota after the insolvency occurs. Claims are paid from this assessment.

THIS POLICY OR CONTRACT IS NOT PROTECTED BY THE MINNESOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION OR THE MINNESOTA INSURANCE GUARANTY ASSOCIATION. IN THE CASE OF INSOLVENCY, PAYMENT OF CLAIMS IS NOT GUARANTEED. ONLY THE ASSETS OF THIS INSURER WILL BE AVAILABLE TO PAY YOUR CLAIM.

THIS NOTICE IS REQUIRED BY MINNESOTA STATE LAW TO ADVISE POLICYHOLDERS OF LIFE, ANNUITY, OR HEALTH INSURANCE POLICIES OF THEIR RIGHTS IN THE EVENT THEIR INSURANCE CARRIER BECOMES FINANCIALLY INSOLVENT. THIS NOTICE IN NO WAY IMPLIES THAT THE COMPANY CURRENTLY HAS ANY TYPE OF FINANCIAL PROBLEMS. ALL LIFE, ANNUITY, AND HEALTH INSURANCE POLICIES ARE REQUIRED TO PROVIDE THIS NOTICE.