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 TO COMPLETE

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

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

Special Enrollment Event: *(date of event)*: _____

☐ Employment Termination/Reduction in Work Hours ☐ Child Loses Dependent Status ☐ Death
☐ Employer Contributions Terminated for Non-COBRA Coverage ☐ Involuntary Loss of Other Coverage*
☐ Divorce/Legal Separation ☐ Birth ☐ Adoption/Placement for Adoption* ☐ Marriage
☐ COBRA Exhaustion ☐ Qualified Medical Child Support Order* ☐ Move outside of HMO Service Area
☐ Eligibility/Loss of Children Health Insurance Program (CHIP)/Medicaid*
Other Reason: _____ *(* provide documentation)*

START DATE OF FULL-TIME EMPLOYMENT _____ month / day / year
HOURS WORKED PER WEEK
COVERAGE EFFECTIVE DATE _____ month / day / year

SIGNATURE OF EMPLOYER **X** _____
DATE SIGNED _____ month / day / year

EMPLOYEE TO COMPLETE

EMPLOYEE'S LAST NAME (LEGAL NAME)	FIRST NAME	M.I.	DATE OF BIRTH month day year	SOCIAL SECURITY NUMBER *(Required for Mandatory Federal/IRS Reporting[1])*

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 health coverage in addition to this plan? ☐ NO ☐ YES

If YES, name(s): _____ ☐ Single coverage ☐ Family coverage

Name of insurance company: _____

Are you enrolled in 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 enrolled in Medicare Part A, B or D? ☐ NO ☐ YES Name: _____

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

Reason for Medicare Coverage: ☐ Age 65 or older ☐ Under age 65 with a disability ☐ Under age 65 with end stage renal disease

Do you or any family members included on this enrollment form have past or current medical coverage through a contract or plan through PreferredOne Community Health Plan (PCHP), PreferredOne Administrative Services (PAS), or PreferredOne Insurance Company (PIC)? ☐ NO ☐ YES

If YES, please provide Employer Name (for group coverage): _____

Name(s) of all covered person(s): _____

By executing and submitting this enrollment form, you give PIC/PCHP permission to view all claims history for you and your family members as a result of such coverage except for claims history that PAS obtained acting in its capacity as a preferred provider organization (PPO).

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

[1] Federal law requires that we obtain Social Security numbers for annual information reporting to the IRS; however, please note that they are not used in determining the eligibility of any applicant or dependent for coverage.

MEMBER ENROLLMENT FORM

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

LAST NAME ONLY IF DIFFERENT FROM ABOVE	FIRST NAME	M.I.	RELATIONSHIP	SEX M F	DATE OF BIRTH month day year	SOC. SECURITY NO. *(Required for Mandatory Federal/IRS Reporting[1])*

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 disability, developmental disability, mental illness or mental health disorder and dependent on the employee for a majority of their financial support and maintenance? 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.

_____

[1] Federal law requires that we obtain Social Security numbers for annual information reporting to the IRS; however, please note that they are not used in determining the eligibility of any applicant or dependent for coverage.

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

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 I have coverage through: Spouse's Group Plan Medicare COBRA/State Continuation MNCare Individual Policy Medical Assistance Other coverage reason: _____

Alternately, I am NOT applying for coverage because of: Cost Network 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 apply for coverage within 31 days after the date other coverage ends, you lose eligibility for coverage or the employer stops contributing to your coverage. If you newly gain a spouse or eligible dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new spouse, along with your new dependent, provided that you apply for enrollment within 31 days after the date of the 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.

AUTHORIZATIONS for PreferredOne and Others to Receive, Disclose and Use ("Share") Your Health Information

I, the applicant, for myself and any [minor] dependents, authorize PreferredOne, my health plan, my insurer, and my providers to Share my Health Information specifically by and with, but not limited to, the following:

- PreferredOne, for its plan administration, payment and/or operations
- [Providers – in their role as accountable care-type organizations or networks or under other designated financial or contractual arrangements, so that individually and collectively they can better manage my overall health status and my specific health conditions and diseases, through care coordination, quality improvement, and disease management functions, and/or various payment arrangements]
- Payers -- Medicare, Medicaid and/or any other government health care programs, any other insurance company, health maintenance organization, payer network organization including an accountable care-type organization or network or other payer, and the contractors and subcontractors of such entities, for the payment and operations purposes of PreferredOne and each of them
- PreferredOne's contractor and subcontractor service providers, including but not limited to PreferredOne Insurance Company and PreferredOne Community Health Plan (collectively "PreferredOne") and their affiliate PreferredOne Administrative Services, Inc. (all collectively "affiliates") – to assist PreferredOne in carrying out its plan administration, payment and operations functions–including but not limited to coordinating benefits between payers, coordinating out-of-pocket payments for medical and pharmacy claims, pharmacy benefit management, disease and care management, utilization review and management, and other customer service and health claim-related activities

MEMBER ENROLLMENT FORM

I understand and agree as follows:

- I will execute and submit all authorizations required by any third party (e.g., providers) for the release of my Health Information to PreferredOne for plan administration, payment and/or operations purposes.
- My "Health Information" includes, but is not limited to, my "protected health information" or "PHI" as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and my "health records" as defined by Minnesota Statutes section 144.293; and includes my past, present and future health records, which include but are not limited to, medical and pharmacy claims and related case notes, and information derived from them. These specifically include claims and case notes about HIV/AIDS, mental health and psychotherapy, substance use, and/or chemical dependency treatment.
- I am not allowed to modify the authorizations in this enrollment form; and if I do so, the enrollment form will not be valid.
- This authorization shall remain valid as long as I am enrolled in health care coverage provided or administered by PreferredOne and its affiliates, unless I revoke it as described below. A copy of this authorization is valid as the original.
- This authorization is effective notwithstanding any other authorizations or revocations of authorizations that I enter into or have already entered into with PreferredOne, its affiliates and/or any providers. This authorization and any expiration or revocation thereof does not affect or change the routine sharing of my Health Information by or between PreferredOne, its affiliates and/or any providers, that is permitted or required under HIPAA or applicable state law.
- Information released pursuant to this authorization may be re-disclosed as permitted by law, in which case I understand that it may no longer be protected under federal privacy rules. I may revoke this authorization prospectively at any time, but only by submitting a valid written revocation to PreferredOne's Customer Service Department; and can obtain revocation information from the Customer Service Department by calling (763) 847-4477 or toll free at 1-800-997-1750. Such revocation will be effective only after PreferredOne receives it, and it will not affect PreferredOne's or others' actions taken prior to receipt of the revocation.

ACKNOWLEDGEMENTS

To the best of my knowledge and belief the answers to the questions and the statements made on this completed enrollment form are true and complete, and I agree that any telephone conversations required to clarify information on this completed enrollment form are part of this enrollment form.

I further understand and agree as follows:

- If this form is submitted because of a special enrollment event, then this form amends my original enrollment form and will be incorporated into and made a part of the enrollment form and certificate of coverage.
- Payment of a claim does not prevent PreferredOne from denying future claims or taking any lawful action it determines appropriate, including rescission of the certificate of coverage and seeking repayment of claims already paid.
- If PreferredOne approves this enrollment form, it will issue a certificate of coverage for me and, if applicable, the dependents listed in this form.
- In the event of a conflict between this enrollment form and the certificate of coverage, the certificate of coverage governs and PreferredOne will administer coverage in accordance with the certificate of coverage.
- I am not allowed to modify the acknowledgements in this enrollment form; and if I do so, the enrollment form will not be valid. PreferredOne reserves and has the right to, in its sole discretion, request and/or rely on other documentation, to determine if any person listed in this enrollment form satisfies the requirements of this enrollment form.
- PreferredOne will act in reliance upon the information I have provided herein.
- **I must update the information that I have provided on this enrollment form and resubmit it if any changes to the information take place between submission of the enrollment form and the effective date of coverage; and, failing to notify PreferredOne of any change, providing false information or the omission of relevant information on this enrollment form which materially affects either the acceptance of risk or hazard assumed by PreferredOne may result in denial of claims, rescission of coverage, or an increase in premiums, and may be considered insurance fraud.**

If my employer offers coverage for domestic partners, and I elect coverage for my domestic partner, I certify that my domestic partner and I: share the same permanent residence; are jointly responsible for basic living expenses; are not married to anyone and are each other's sole domestic partner with the intent to remain together indefinitely; are not related by blood closer than permitted under Minnesota marriage laws; are each mentally competent to consent to a contract; have completed or will complete a domestic partner affidavit form and have agreed or will agree to the conditions of such form.

❑ Yes ❑ No If PreferredOne issues coverage to me, I consent to receiving via email at the email address I provided herein, notice of the availability through the Internet and to electronic delivery of the following information: coverage documents, explanations of benefits, adverse determination notices, and summaries of benefits and coverage. I understand that PreferredOne will notify me when these documents are newly available, of the document's significance, and how to access the document at www.preferredone.com. I understand that, if I consent to email notice and electronic delivery, I may also request a paper copy of these documents from PreferredOne's Customer Service Department.

IF APPLYING FOR COVERAGE SIGNATURE OF EMPLOYEE *(required)* **X** _____	DATE SIGNED _____ month / day / year