igniting a passion

EMPLOYEE BENEFIT ENROLLMENT/CHANGE FORM

Effective Date: _____

FAX: 651-425-6258
Interoffice Mail: Human Resources @ DSC

A. EMPLOYEE INFORMATION

Last Name	First Name	Middle Initial	Birthdate	Gender

Street Address	Apt. No.	City	State	Zip Code

Home Phone	Work Phone	Cell Phone	Marital Status	
			❑ Single ❑ Divorced	❑ Legally Married ❑ Legally Separated

Social Security Number (required)	Position	Date of Hire	Email Address

❑ New Hire or Newly Eligible ❑ Change due to IRS Qualified Life Event ❑ Cancel All Coverage ❑ Change from Family to Single Coverage

B. MEDICAL INSURANCE

Application for Medical Plan (PCH10638):

❑ Open Access $25 Copay
❑ Open Access $15 Copay
❑ Open Access HDHP w/VEBA

❑ Single
❑ Family
❑ Adding Dependent - Simply list dependent being added in the family information section
❑ Cancel All Coverage
❑ Cancel Select Dependents
List Dependents to be removed:
_____

C. FAMILY INFORMATION

List all family members to be covered.	Gender M or F	Birthdate Mo./Day/Year	Relationship to Applicant	Social Security Number (Required)
Employee Name (First, Middle, Last)	N/A	N/A	**SELF**	N/A
Legally Married Spouse Name (First, Middle, Last)			**SPOUSE**	
Other Dependents Name (First, Middle, Last)				
Other Dependents Name (First, Middle, Last)				
Other Dependents Name (First, Middle, Last)				
Other Dependents Name (First, Middle, Last)				

Please add additional dependents on a separate sheet of paper and attach to this enrollment form.

Dependent children are covered to age 26, Handicapped dependents over age 26 that are financially dependent are eligible for coverage. Please fill in the information noted here if applicable. You will receive a request for additional information.

Name **Handicapped Yes or No**

D. OTHER HEALTH INSURANCE INFORMATION (Fill out this section ONLY if you are electing medical and/or dental coverage)

- On the day your coverage begins, will you or the dependents listed above be covered by other health insurance, or Medicare? ❑ Yes ❑ No
- If yes, complete this section. Use extra paper if more than one additional policy will be in force.

Coverage Type	Name of Policyholder	Policyholder's Birthdate	Policyholder's Employer Name/Address/Phone Number
❑ Medical Insurance ❑ Medicare			

Insurance Company Name and Phone Number	Effective Date	Policy Number(s)	Family Members Covered
Medical:			

Name of family members covered by Medicare	Medicare Number	Part A Effective Date	Part B Effective Date

AUTHORIZATIONS

For PreferredOne and Others (including Delta and Standard) to Receive, Disclose and Use ("Share") Your Health Information

I, for myself, and as applicable, any minor dependents, spouse or dependents age 18 or older covered by the medical plan option in which I am enrolling with this form, hereby authorize PreferredOne to use and disclose my health information, including my protected health information as defined by HIPAA, claim information and explanation of benefits information ("Health Information"), to any health care provider and any subcontractor of a health care provider or of PreferredOne that provides services for, or in connection with the medical plan option in which I am enrolling with this form; and I also authorize health care providers and the contractors and/or subcontractors of health care providers to use and disclose my health information to PreferredOne with all such disclosures described herein between PreferredOne, health care providers and contractors and/or subcontractors of health care providers for the purpose of managing my overall health status, my health conditions and diseases; for care coordination and quality improvement purposes; for disease management purposes; and for claim processing and payment purposes. This authorization also specifically allows PreferredOne, health care providers and contractors and/or subcontractors to share my health information about care I have received or may receive in the future.

I, for myself, and as applicable, any minor dependents, spouse or dependents age 18 or older covered by the medical plan option in which I am enrolling with this form, hereby 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 – with respect to coverage and payment; 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; and in their role as accountable care-type organizations or networks or under other designated financial or contractual 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's controlled group affiliates ("affiliates") – that 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

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 and notify PreferredOne of any change to the information that I have provided on this enrollment form that 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.**
- **I must also notify PreferredOne after coverage is effective of any changes to my information including my email address.**

If PreferredOne issues coverage to me, I consent to receiving, through my secure member home page at www.preferredone.com, electronic delivery (in lieu of paper delivery) of the following information to the extent that PreferredOne makes them available electronically: coverage documents, explanations of benefits, adverse determination notices, and summaries of benefits and coverage. I understand that PreferredOne will notify me by email when such information is newly available, of the document's significance, and how to access the document at www.preferredone.com. I understand that I may request a paper copy of these documents and/or to opt out of exclusively electronic delivery by contacting PreferredOne's Customer Service Department at 1-800-997-1750 or (763) 847-4477 or accessing www.preferredone.com.

SIGNATURES - By signing below, I certify under penalty of perjury that: (i) I have completely read and fully understand the terms and conditions of this enrollment form; (ii) all the representations in this enrollment form are made by me and are true and complete; and (iii) I agree to the statements, authorizations, acknowledgements and terms of this enrollment form. I understand that any misrepresentation may result in the forfeiture of insurance coverage and that I will be personally responsible for all claims affected by such misrepresentation. I understand that I may be subject to penalties under law if I provide false or untrue information.

Employee: _____ Date: _____

Employer: _____ Date: _____