

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

EMPLOYER TO COMPLETE						
NAME OF EMPLOYER		GROUP NUMBER	CLASS	NETWORK	SUB-GROUP	PLAN
<input type="checkbox"/> New Hire <input type="checkbox"/> Open Enrollment <input type="checkbox"/> COBRA (begin date) _____ <input type="checkbox"/> Early Retiree <input type="checkbox"/> Rehire <input type="checkbox"/> Late Entrant (dental only) <input type="checkbox"/> ACA Stability/Look Back Event		Special Enrollment Event: (date of event): _____ <input type="checkbox"/> Employment Termination/Reduction in Work Hours <input type="checkbox"/> Child Loses Dependent Status <input type="checkbox"/> Death <input type="checkbox"/> Employer Contributions terminated for Non-COBRA Coverage <input type="checkbox"/> Involuntary Loss of Other Coverage* <input type="checkbox"/> Divorce/Legal Separation <input type="checkbox"/> Birth <input type="checkbox"/> Adoption/Placement for Adoption* <input type="checkbox"/> Marriage <input type="checkbox"/> COBRA Exhaustion <input type="checkbox"/> Qualified Medical Child Support Order* <input type="checkbox"/> Eligibility/Loss of Children Health Insurance Program (CHIP)/Medicaid* <input type="checkbox"/> Other Reason: _____ (*provide documentation)				
HOURS WORKED PER WEEK		START DATE OF FULL-TIME EMPLOYMENT		COVERAGE EFFECTIVE DATE		
		month / day / year		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	SOCIAL SECURITY NUMBER	
				month / day / year	(Required for Mandatory Federal Reporting/IRS Reporting ¹)	
STREET ADDRESS / APT. NO.			CITY	STATE	ZIP	COUNTY
EMPLOYEE'S TELEPHONE			E-MAIL ADDRESS		<input type="checkbox"/> MALE	<input type="checkbox"/> SINGLE
HOME / CELL: _____			BUSINESS: _____		<input type="checkbox"/> FEMALE	<input type="checkbox"/> MARRIED
Do you or any family members listed below have other health coverage in addition to this plan? <input type="checkbox"/> NO <input type="checkbox"/> YES - Type: <input type="checkbox"/> Medical If YES, name(s): _____ <input type="checkbox"/> Single coverage or <input type="checkbox"/> Family coverage Name of insurance company: _____						
Are you enrolled in or eligible for Medicare Part A, B or D? <input type="checkbox"/> NO <input type="checkbox"/> 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 or eligible for Medicare Part A, B or D? <input type="checkbox"/> NO <input type="checkbox"/> YES If YES (attach a copy of Medicare card) effective date: Part A _____ Part B _____ Part D _____						
Reason for Medicare Coverage: <input type="checkbox"/> Age 65 or older <input type="checkbox"/> Under age 65 with a disability <input type="checkbox"/> 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)? <input type="checkbox"/> NO <input type="checkbox"/> 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 PAS 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).						
<input type="checkbox"/> I ACCEPT COVERAGE FOR: <input type="checkbox"/> Medical: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Children (to age 26 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.	RELATIONSHIP	SEX M F	DATE OF BIRTH month day year	SOC. SECURITY NO. (Required for Mandatory Federal Reporting/IRS Reporting ¹)
Do all of the dependent(s) listed above reside at the same address as the employee? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> NO <input type="checkbox"/> YES If YES, list dependents(s) and date of onset of physical or mental disability and please provide supporting documentation as proof of incapacity.						

¹Federal 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
NAME _____

SOC.
SEC. # _____

MEMBER ENROLLMENT FORM

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 _____	<input type="checkbox"/> Part-time	<input type="checkbox"/> Full-time
NAME _____	SCHOOL _____	<input type="checkbox"/> Part-time	<input type="checkbox"/> 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

I am NOT applying for coverage because I have coverage through: Spouse's Group Plan Medicare Group Coverage Continuation
 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 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 marriage and a covered employee may, within 60 days, 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.

AUTHORIZATIONS for PreferredOne Administrative Services, Inc. (PAS) and Others to Receive, Disclose and Use ("Share") Your Health Information

I, the applicant, for myself (and if applicable) my dependent applicants, authorize PAS, my employer health plan, and my providers to Share my Health Information specifically by and with, but not limited to, the following:

- PAS, for its plan administration, payment and/or operations
- 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
- PAS's contractor and subcontractor service providers, including but not limited to PreferredOne Insurance Company and PreferredOne Community Health Plan (all collectively "affiliates") - to assist PAS 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 PAS 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" 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 through my employer health plan and administered through PAS, unless I revoke it as described below. A copy of this authorization is as 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 my employer health plan, PAS, 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 my employer health plan, or between PAS, 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 my employer health plan, or PAS'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 PAS receives it, and it will not affect PAS's or others' actions taken prior to receipt of the revocation.

By signing below, I certify that I have read, understand and agree to the above listed statements and the terms of this enrollment form.

IF APPLYING FOR COVERAGE	DATE SIGNED
SIGNATURE OF EMPLOYEE X _____	month / day / year