PreferredOne®
ADMINISTRATIVE SERVICES

MEMBER ENROLLMENT FORM

P.O. Box 59212
Minneapolis, MN 55459-0212
Customer Service (763) 847-4477 1-800-997-1750

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

☐ New Hire
☐ Open Enrollment
☐ COBRA *(begin date)* _____
☐ Early Retiree
☐ Rehire
☐ Late Entrant (dental only)
☐ ACA Stability/Look Back Event

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*
☐ Eligibility/Loss of Children Health Insurance Program (CHIP)/Medicaid*
☐ Other Reason: _____ *(*provide documentation)*

HOURS WORKED PER WEEK

START DATE OF FULL-TIME EMPLOYMENT _____ month / day / year

COVERAGE EFFECTIVE DATE _____ month / day / year

SIGNATURE OF EMPLOYER X _____ (required)

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 Reporting/IRS Reporting[1])*

STREET ADDRESS / APT. NO.	CITY	STATE	ZIP	COUNTY

EMPLOYEE'S TELEPHONE HOME / CELL: 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 - **Type:** ☐ Medical
If YES, name(s): _____ ☐ Single coverage or ☐ Family coverage
Name of insurance company: _____

Are you enrolled in 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 enrolled in 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 _____

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 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).

☐ **I ACCEPT COVERAGE FOR:** ☐ **Medical:** ☐ Self ☐ Spouse ☐ 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? ☐ 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 dependents(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.

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 _____ ☐ 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

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
SIGNATURE OF EMPLOYEE X _____ DATE SIGNED _____ month / day / year