Southeastern Minnesota Center for Independent Living

MEC Enrollment Form

Group # 216124

Employer Use Only			
Date of Hire	Effective Date	Payroll Effective Date	Location/Department

EMPLOYEE INFORMATION

Legal Last Name	Legal First Name	Middle Initial

Home Address	City	State	Zip Code

Home Telephone Number ( )	Cell Number ( )	Date of Birth	☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated

Social Security Number	Primary E-mail Address	Secondary E-mail Address:

If you wish to have your Explanation of Benefits (EOB) sent to your primary e-mail address, please check . ☐ Yes ☐ No
Note: If you choose to have it sent electronically, you **will not** receive a hard copy via regular mail.

PLAN

Choose Plan Below:

☐ Minimum Essential Coverage (MEC) Plan

COVERAGE

Choose level below: **OR** **Choose one below:****

☐ Employee
☐ Employee + Spouse
☐ Employee + Child(ren)
☐ Family

☐ I waive coverage, I DO NOT have other coverage
☐ I waive coverage, I HAVE other coverage
(*"other coverage" can include a spouse's group plan, an individual plan purchased on an exchange, Medicare/Medicaid, Tricare*)

**If waiving coverage as a result of having other coverage, employee will be required to provide proof of coverage. Please include a copy of a current ID card and/or certificate of coverage with this enrollment form.

DEPENDENT INFORMATION

Complete the following information for each dependent (including spouse) to be covered.

Name: Last, First, MI	Date of Birth M	D	Y	Relationship	Gender (M / F)	Social Security Number ***(Required)***
				Spouse		

(List additional children on a separate sheet of paper. Also provide address for children if different from employee's mailing address.)

AUTHORIZATION AGREEMENT

- I understand that in order to be eligible for the coverages I have elected, I must meet any applicable actively at work requirement as defined by the insurance contracts.
- I authorize any physician, medical practitioner, hospital, clinic, or medical related facility, insurance or reinsurance company, having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or my minor children and any other non-medical information of me or my minor children to give to our Insurance Companies or their legal representative, any and all such information. I authorize the use and disclosure of my Social Security Number in the administration and provision of such benefits as may apply to me or my minor children.
- I understand Special Enrollment Rules may apply if I waive coverage for myself or my dependents when initially eligible, due to other health insurance coverage. If I do not qualify under the Special Enrollment Rules, enrollment will be restricted to once a year during the annual open enrollment period.
- I understand that providing false information or omission of relevant information on this form may result in the denial of claim(s) and/or termination of coverage.
- I authorize the Company to reduce my regular compensation per pay period for all employee benefits which I have elected and deductions made for the purpose of recovering any ineligible benefit payments. This authorization shall remain in force for this Plan Year and each subsequent Plan Year, or until my participation in the employee benefit plan(s) terminates.
- By providing my e-mail address, I Authorize and Consent to the use of e-mail for communications regarding my employee benefits. I understand that my e-mail address is private and will be used solely for benefit administration purposes.

Signature_____ Date_____

Please return signed copy and proof of other coverage if required to your supervisor/manager or HR Dept.*

Other Insurance Inquiry Form

We are required to obtain current Other Insurance Information. If you or your dependents are enrolled in the medical coverage, this form must be completed and returned with your Enrollment Form before any claims can be processed. In the future, Other Insurance Information will be requested annually. Other insurance may include, but is not limited to: coverage through a spouse's plan, court ordered insurance coverage by a former spouse, coverage required in a divorce decree or paternity suit, or Medicare. Missing or inadequate information may cause claims to be delayed or denied.

Section I – Other Insurance Information
Please answer the question below. If you answer yes, please complete the rest of Section I.

Are any of your family members covered under any other group medical or Medicare? ☐ Yes ☐ No
If you checked yes, you must provide the following information. If you have more than one policy in force, please attach a separate sheet to this form which lists the following information for each policy. If you checked no, skip to Section II and complete.

Types of Coverage (please check all that apply): ☐ Medical ☐ Medicare	Policyholder's Name		Policyholder's Birthdate
Policyholder's Employer Name	Address		Phone Number
Insurance Company Name and Phone Number	Policy Number	Family Members Covered	
Names of family members covered by Medicare			Medicare ID #:
Medicare Part A Eff. Date: / /	Medicare Part B Eff. Date: / /	Is Medicare eligibility due to : ☐ Kidney Failure ☐ Disability	

Is coverage for any of the above listed individuals required due to a court order, divorce decree or paternity suit? ☐ Yes ☐ No

If Yes, who has financial responsibility? Name:

Relationship:	Primary Residence of Dependents:
If both parties maintain insurance on the children, which parent has custody?	
Please attach a copy of the section of the court order or divorce decree pertaining to health coverage. If you have previously provided this information to EBSO and that information is still current, you do not need to submit it again.	

Section II – Signature

I hereby certify that the information I have provided above is true and correct and, I authorize any insurance company, plan administrator, or educational institution to release any information regarding other insurance coverage or student status regarding me or my covered dependents to EBSO for the purpose of benefit coordination.

I UNDERSTAND THAT PROVIDING FALSE INFORMATION OR OMISSION OF RELEVANT INFORMATION ON THIS FORM MAY RESULT IN THE DENIAL OF CLAIM(S) AND/OR TERMINATION OF COVERAGE.

Employee Name (print)_____ Social Security # _____

Employee Signature_____ Date_____