

2008 SMALL EMPLOYER MEMBER ENROLLMENT FORM

PLEASE KEEP A COPY OF THIS FORM FOR YOUR RECORDS

PreferredOne[®]
PREFERREDONE INSURANCE COMPANY
PREFERREDONE COMMUNITY HEALTH PLAN



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**SMALL EMPLOYER
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 COMPLETE

<input type="checkbox"/> PIC <input type="checkbox"/> PCHP	NAME OF EMPLOYER	GROUP NUMBER	CLASS	SUB-GROUP	PRODUCT
<input type="checkbox"/> New Hire <input type="checkbox"/> Late Enrollment <input type="checkbox"/> MN Con. (COBRA) Begin Date _____ <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Early Retiree <input type="checkbox"/> Retiree <input type="checkbox"/> Special Enrollment: Date _____ <input type="checkbox"/> Termination/reduction in work hours <input type="checkbox"/> Employer contributions terminated <input type="checkbox"/> Divorce/legal separation <input type="checkbox"/> Death <input type="checkbox"/> Birth/adoption <input type="checkbox"/> Marriage					
QUALIFYING EVENT	HOURS WORKED PER WEEK	DATE OF FULL-TIME EMPLOYMENT _____ month / day / year		COVERAGE EFFECTIVE DATE _____ month / day / year	
SIGNATURE OF EMPLOYER X _____				DATE SIGNED _____ month / day / year	

EMPLOYEE COMPLETE

EMPLOYEE'S LAST NAME (LEGAL NAME)	FIRST NAME	M.I.	DATE OF BIRTH	SOCIAL SECURITY NUMBER		
STREET ADDRESS / APT. NO.		CITY	STATE	ZIP	HEIGHT	WEIGHT
EMPLOYEE'S TELEPHONE HOME () BUSINESS ()			E-MAIL ADDRESS		<input type="checkbox"/> MALE <input type="checkbox"/> SINGLE	<input type="checkbox"/> FEMALE <input type="checkbox"/> MARRIED

Do you or any family members listed below have other coverage in addition to this plan? NO YES
 If YES, name(s) _____ Single coverage or Family coverage
 Name of insurance company _____

Are you covered by 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 covered by 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 _____

Do you or any family members included on this enrollment form currently have or have you had continuous health coverage for the last twelve months (18 months for late enrollees)? NO YES
 If YES please list carrier name, effective date and termination date _____

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). For proprietary reasons, PPO claims history information will not be reviewed as part of the PIC/PCHP underwriting process.

I ACCEPT COVERAGE FOR: Self Spouse Children (through age 24 or disabled. If disabled, see below)

FILL IN THE FOLLOWING INFORMATION FOR EACH ELIGIBLE DEPENDENT TO BE COVERED (Married children are not eligible)

LAST NAME ONLY IF DIFFERENT FROM ABOVE	FIRST NAME	M.I.	RELATIONSHIP	SEX M F	DATE OF BIRTH month day year	HGT.	WGT.	SOC. SECURITY NO.

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 _____

MEMBER NAME _____ SOC. SEC. # _____

SMALL EMPLOYER MEMBER ENROLLMENT FORM

FOR USE PRIOR TO 2008 EFFECTIVE/RENEWAL DATE. THEREAFTER USE FOR UNINSURED 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

HEALTH INFORMATION

1. Have you or any family member eligible for coverage in the LAST FIVE YEARS, been treated for, or diagnosed with, any of the following medical conditions? YES NO If YES (please check all that apply and list details below).

- back disorder
- blood disorder
- counseling services
- eye or ear disorder
- digestive or intestinal disorder
- drug use
- eating disorder
- headache/migraine
- muscle, bone or joint disorder
- psychological or neurological disorder
- reproduction system disorder
- respiratory disorder/asthma

2. Have you or any family member eligible for coverage, EVER been treated for, or diagnosed with, any of the following medical conditions? YES NO If YES (please check all that apply and list details below).

- allergies
- arthritis
- cancer
- diabetes
- heart or circulatory disorder
- immune system disorder
- kidney or urinary tract disorder
- liver disorder
- seizure/epilepsy
- stroke
- thyroid disorder

YES NO Is anyone currently pregnant? If YES, please list below the due date, describe any complications experienced or if multiple births are expected.

YES NO Have you or any family member applying for coverage been diagnosed with a medical condition not already listed on the enrollment form? (If YES, explain below).

3. Have you or any family member eligible for coverage in the LAST FIVE YEARS:

- YES NO Been convicted of a DWI/DUI or been medically treated for alcohol or drug use?
- YES NO Consulted with a physician concerning bariatric surgery?
- YES NO Currently have a medical condition that may require medical, surgical or hospital care?
- YES NO Been hospitalized or had surgery for any condition or injury?

4. If you have checked any boxes in 1, 2 or 3 above, please give details below:

Person's Name	Diagnosis and Details About Condition and Treatment	Date of Diagnosis	Date of Recovery	Days in Hospital
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

5. MEDICATIONS: For each person eligible for coverage, complete the following (list ALL PAST and PRESENT medications used)

Person's Name	Medication	Reason Prescribed	Dosage (mg/gm)	# Per Day	Refills Per Year	Still Prescribed?
_____	_____	_____	_____	_____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO
_____	_____	_____	_____	_____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO
_____	_____	_____	_____	_____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO
_____	_____	_____	_____	_____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO

Are any age 25 or older dependents listed above incapable of self-sustaining employment because of physical or mental disability and dependent on the employee for a majority of their financial support? NO YES

If YES, list dependent(s) and date of onset of physical or mental disability _____

If yes, please provide supporting documentation.

APPLIES ONLY TO PREFERREDONE INSURANCE COMPANY PLANS.

PreferredOne Insurance Company

6105 Golden Hills Drive
Golden Valley, MN 55416
763.847.4477 1.800.997.1750

**NOTICE CONCERNING POLICYHOLDER RIGHTS IN AN INSOLVENCY UNDER THE MINNESOTA LIFE AND HEALTH INSURANCE
GUARANTY ASSOCIATION LAW.**

If the insurer that issued your life, annuity, or health insurance policy becomes impaired or insolvent, you are entitled to compensation for your policy from the assets of that insurer. The amount you recover will depend on the financial condition of the insurer.

In addition, residents of Minnesota who purchase life insurance, annuities, or health insurance from insurance companies authorized to do business in Minnesota are protected, SUBJECT TO LIMITS AND EXCLUSIONS, in the event the insurer becomes financially impaired or insolvent. This protection is provided by the Minnesota Life and Health Insurance Guaranty Association.

Minnesota Life and Health Insurance Guaranty Association
4760 White Bear Parkway Suite 101
White Bear Lake, MN 55110
Phone Number: 651.407.3149 Fax Number: 651.407.3150

The maximum amount the guaranty association will pay for all policies issued on one life by the same insurer is limited to \$300,000. Subject to this \$300,000 limit, the guaranty association will pay up to \$300,000 in life insurance death benefits, \$100,000 in net cash surrender and net cash withdrawal values for life insurance, \$300,000 in health insurance benefits, including any net cash surrender and net cash withdrawal values, \$100,000 in annuity net cash surrender and net cash withdrawal values, \$300,000 in present value of annuity benefits for annuities which are part of a structured settlement or for annuities in regard to which periodic annuity benefits, for a period of not less than the annuitant's lifetime or for a period certain of not less than ten years, have begun to be paid on or before the date of impairment or insolvency, or if no coverage limit has been specified for a covered policy or benefit, the coverage limit shall be \$300,000 in present value. Unallocated annuity contracts issued to retirement plans, other than defined benefit plans, established under section 401, 403(b), or 457 of the Internal Revenue Code of 1986, as amended through December 31, 1992, are covered up to \$100,000 in net cash surrender and net cash withdrawal values, for Minnesota residents covered by the plan provided, however, that the association shall not be responsible for more than \$7,500,000 in claims from all Minnesota residents covered by the plan. If total claims exceed \$7,500,000, the \$7,500,000 shall be prorated among all claimants. These are the maximum claim amounts. Coverage by the guaranty association is also subject to other substantial limitations and exclusions and requires continued residency in Minnesota. If your claim exceeds the guaranty association's limits, you may still recover a part or all of that amount from the proceeds of the liquidation of the insolvent insurer, if any exist. Funds to pay claims may not be immediately available. The guaranty association assesses insurers licensed to sell life and health insurance in Minnesota after the insolvency occurs. Claims are paid from this assessment.

THE COVERAGE PROVIDED BY THE GUARANTY ASSOCIATION IS NOT A SUBSTITUTE FOR USING CARE IN SELECTING INSURANCE COMPANIES THAT ARE WELL MANAGED AND FINANCIALLY STABLE. IN SELECTING AN INSURANCE COMPANY OR POLICY, YOU SHOULD NOT RELY ON COVERAGE BY THE GUARANTY ASSOCIATION.

THIS NOTICE IS REQUIRED BY MINNESOTA STATE LAW TO ADVISE POLICYHOLDERS OF LIFE, ANNUITY, OR HEALTH INSURANCE POLICIES OF THEIR RIGHTS IN THE EVENT THEIR INSURANCE CARRIER BECOMES FINANCIALLY INSOLVENT. THIS NOTICE IN NO WAY IMPLIES THAT THE COMPANY CURRENTLY HAS ANY TYPE OF FINANCIAL PROBLEMS. ALL LIFE, ANNUITY, AND HEALTH INSURANCE POLICIES ARE REQUIRED TO PROVIDE THIS NOTICE.