

MEDICA

HEALTH BENEFITS ENROLLMENT AND ELECTION FORM

- I ELECT THIS COVERAGE.** (SIGN AND DATE, YOU MUST COMPLETE THE INFORMATION BELOW.)
 By electing coverage and signing below, I hereby accept the benefits applied for and authorize General Parts to make payroll deductions for the benefits elected. My share of the premium for group health insurance is automatically deducted from my paycheck on a pre-tax basis (before state, federal, or FICA taxes are withheld.)
- I DECLINE THIS COVERAGE.** (SIGN AND DATE, YOU MAY SKIP TO THE NEXT SECTION)

NAME (Print) _____

SIGNATURE _____ DATE _____

*******EMPLOYEE TO COMPLETE THE FOLLOWING IF ELECTING COVERAGE*******

<input type="checkbox"/> NEW ENROLLEE PLAN REQUESTED: <input type="checkbox"/> PPO OPTION <input type="checkbox"/> VEBA/HRA COVERAGE REQUESTED <input type="checkbox"/> EMPLOYEE COVERAGE <input type="checkbox"/> EMPLOYEE + 1 <input type="checkbox"/> FAMILY	<input type="checkbox"/> OPEN ENROLLMENT EFFECTIVE DATE _____ <input type="checkbox"/> WAIVING COVERAGE FOR: <input type="checkbox"/> MYSELF <input type="checkbox"/> MY SPOUSE <input type="checkbox"/> MY DEPENDENTS REASON FOR WAIVER: <input type="checkbox"/> I (AND OR MY DEPENDENTS) HAVE OTHER GROUP COVERAGE THROUGH: _____ <input type="checkbox"/> OTHER _____
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DEPENDENT INFORMATION (PLEASE COMPLETE IF YOU ARE ENROLLING DEPENDENTS FOR COVERAGE)					
DEPENDENT NAME (FIRST MI LAST)	RELATIONSHIP	BIRTH DATE	SEX	SOCIAL SECURITY #	STUDENT (OVER AGE 19)
					<input type="checkbox"/> YES <input type="checkbox"/> NO SCHOOL NAME _____
					<input type="checkbox"/> YES <input type="checkbox"/> NO SCHOOL NAME _____
					<input type="checkbox"/> YES <input type="checkbox"/> NO SCHOOL NAME _____
					<input type="checkbox"/> YES <input type="checkbox"/> NO SCHOOL NAME _____

OTHER HEALTH COVERAGE

Important Note: This coverage does not provide benefits for a condition for which medical advice, diagnosis, care, or treatment (including treatment with prescription drugs) was recommended or received during the 6 months immediately preceding the enrollment date, until the coverage has been active for at least 12 consecutive months, or for late entrants, 18 consecutive months. Credit will be given for prior creditable coverage to reduce the pre-existing condition limitation period.

Do you or any family member listed on this form have current health coverage or had previous health coverage within the last 24 months? YES NO

If "YES" you must fully complete the following section. Starting with the employee, list each family member applying for coverage and include information for all previous coverage in effect during the last 24 months.

Date of Coverage (Last 24 Months)	Name of Insurance Company	Name of All family Members Covered
Start Date: _____ End Date: _____		
Start Date: _____ End Date: _____		
Start Date: _____ End Date: _____		
Start Date: _____ End Date: _____		
Start Date: _____ End Date: _____		

Have you been a Medica member before? YES NO
 On the day your Medica coverage begins, will any family members be covered by any other health insurance or Medicare? YES NO
 Are you or your spouse covered by Medicare? Medicare Number: _____ Effective Date: _____ Part A _____ Part B _____
 Medicare eligibility due to: Age ESRD (End Stage Renal Disease) Disability Condition: _____

FOR OFFICE USE ONLY

COMPANY NAME _____ DIV/DEPT _____
 GROUP # _____ HIRE DATE _____ EFFECT. DATE _____
 OPEN ENROLLMENT SPECIAL ENROLLMENT RETURN FROM LAYOFF/LEAVE NEW HIRE
 STATUS CHANGE FULL TIME HOURLY SALARIED
 APPROVED BY _____ DATE _____
 (Employer Representative's Signature)