MINNESOTA CREDIT UNION EMPLOYEE BENEFITS PLAN

MEDICA®

Association Health Plan Information

SECTION A ASSOCIATION INFORMATION This Section is Completed by MnCUN

Association Health Plan Name

Minnesota Credit Union Employee Benefits Plan

Association Health Plan Approval and Signature

X _____ _____

Approved By | Date Signed

_____ _____ _____

Print Name | Position | Phone Number

SECTION B PARTICIPATING EMPLOYER INFORMATION

Company Legal Name *(including dba)*	Federal Tax I.D. Number

Address (Must be a physical address, no P.O. Boxes)

Street

City	State	ZIP Code	County

Billing Address (If different than above, P.O. Box accepted)

Street

City	State	ZIP Code	County

Contact Information

Name	Email Address

Phone Number (and extension)	Fax Number

Total Number of Current Employees	Total Eligible Employees	Total Eligible Employees Applying for Coverage

Requested Effective Date	Requested Term Date
____ / ____ / _____	____ / ____ / _____