Minnesota Credit Union Employee Benefits Plan
Health History Form

INSTRUCTIONS

IMPORTANT – PLEASE READ BEFORE COMPLETING
Please read and complete your form thoroughly to ensure accurate processing.

■ If **waiving medical coverage,** complete Sections A and C.

Submit all completed forms to: https://web1.zixmail.net/s/welcome.jsp?b=capstonebenefits.

Your Special Enrollment Rights Under HIPAA
If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, adoption, or placement for adoption.

If you or your dependents have lost coverage under Medicaid or a State Children's Health Insurance Plan (SCHIP), you may be able to enroll yourself and/or your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' other coverage ends.

In addition, if you or your dependents become eligible for group health plan premium assistance provided by the Medicaid or SCHIP program, you may be able to enroll yourself and/or your dependents in this plan. You must request enrollment within 60 days after the date you or your dependents are determined to be eligible for premium assistance.

Visit us on the Internet at **www.medica.com**.

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COM20336-1-00919

Minnesota Credit Union Employee Benefits Plan Health History Form

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Please type or print clearly. See back page for instructions.

Group Name:

A. EMPLOYEE INFORMATION

Have you been a Medica member before? ..... ❑ Yes ❑ No

First name (Legal Name) M.I. Last name	Social Security Number	Marital Status ❑ Single ❑ Married
Mailing address Apt. # City	County	State Zip Code

Cell/Home telephone	Work	Sex ❑M ❑F	Birth date (mm/dd/yy)	Height: ___ft. ___ in. Weight: _____ lbs.	Do you or any of your dependents speak a language other than English as your primary language? ❑ Yes ❑No If "Yes," please list name and language:
Email Address					

B. DEPENDENT INFORMATION

List all members to be covered. Write name as it should appear on the I.D. card.

	First name M.I. Last name	Sex	Birth date (mm/dd/yy)	Relationship	Full-time student?
1		❑ M ❑ F			❑ Yes ❑ No
2		❑ M ❑ F			❑ Yes ❑ No
3		❑ M ❑ F			❑ Yes ❑ No
4		❑ M ❑ F			❑ Yes ❑ No

C. WAIVER OF MEDICAL COVERAGE

This entire section must be completed if you or your dependents DO NOT want coverage.

1. I understand that I am eligible for coverage through my employer. I DO NOT want coverage for:
   ❑ Me and my dependents ❑ My spouse ❑ My dependents only

2. The reason I am declining coverage at this time is because I or my dependents have coverage provided through:
   ❑ Spouse's group plan ❑ Individual Policy ❑ South Dakota Risk Pool (dates of coverage): _____
   ❑ Medicare ❑ Group Coverage Continuation (COBRA) ❑ CHAND (dates of coverage): _____
   ❑ MinnesotaCare ❑ Medical Assistance ❑ Other: _____

Employee Signature: **X** _____ Date Signed: _____

(only sign if you are waiving coverage)

D. HEALTH INFORMATION

Required for all members applying for coverage. You should not include any genetic information. That is, please do not include any information related to genetic testing, genetic services, genetic counseling, or genetic diseases, or any medical history or medical information for family members who are not applying for coverage.

Check every yes or no box and circle the medical condition(s) for all questions answered yes, for you and your family members applying for coverage.

1. In the last 5 years, have you or your dependents been diagnosed with or been treated for:

a. Diabetes or sugar, protein or blood in the urine? ❑ Yes ❑ No
Date diagnosed _____ last A1C score _____

b. Asthma, allergies (receiving allergy shots? ❑ Yes ❑ No) , emphysema, lung or respiratory disorder? ❑ Yes ❑ No

c. Digestive disorder, ulcer, hepatitis*; or any disorder of gallbladder, liver, stomach or intestines? ❑ Yes ❑ No

d. Varicose veins, skin ulcerations, phlebitis, or hernia of any kind? ❑ Yes ❑ No

e. Kidney, bladder, prostate or urinary disorder? ❑ Yes ❑ No

f. Disorder of breast or reproductive organs (male or female), infertility, or abnormal menstrual period? ❑ Yes ❑ No

g. Rheumatoid arthritis, osteoarthritis, TMJ, or any disorder of the joints, muscles, back or bones? ❑ Yes ❑ No
Date and type of muskuloskeletal surgery performed _____

h. Any disorder of eyes, ears, nose or throat (excluding glasses)? ❑ Yes ❑ No

2. Have you or your dependents EVER been diagnosed with or been treated for:

a. High blood pressure _____ (last reading), chest pain, heart murmur, shortness of breath, angina or other heart, blood or circulatory disorder? ❑ Yes ❑ No

b. Stroke, multiple sclerosis, cerebral palsy, seizures, headaches or any disorder of the brain or nervous system? ❑ Yes ❑ No

c. Cancer, tumor, cyst, or growth? Stage of cancer _____ ❑ Yes ❑ No
Spread to lymp nodes? ❑ Yes ❑ No

d. Disorders relating to the immune system including HIV positive*, AIDS*, lupus, or any connective tissue disease? ❑ Yes ❑ No

3. In the last 5 years, have you or your dependents:

a. Been treated for alcohol or drug abuse? ❑ Yes ❑ No

b. Been seen for psychological disorders, anxiety, or eating disorders? ❑ Yes ❑ No

c. Had any medical treatment, health, mental or physical impairment, surgery or congenital disorder, not mentioned above? ❑ Yes ❑ No

4. Are you or your dependents:

a. Currently receiving disability for workers' compensation or payments from an auto carrier for any injury? ❑ Yes ❑ No
If yes, final settlement received? ❑ Yes ❑ No
Is ongoing treatment needed? ❑ Yes ❑ No

b. Currently disabled, hospitalized or on medical leave? ❑ Yes ❑ No

c. Currently receiving professional counseling? ❑ Yes ❑ No
If yes, how often? _____

5. Are any persons to be covered pregnant? ❑ Yes ❑ No

If yes, list due date _____
How many births expected? _____
Any complications currently or expected? _____

6. Has anyone in the last year (specify person):

Used tobacco or smokeless products? ❑ Yes ❑ No
Name _____ Date ended _____
Name _____ Date ended _____

7. Do you know of any pending or upcoming treatment? ❑ Yes ❑ No

8. Has any surgery been recommended or advised in the future? ❑ Yes ❑ No

9. Have you taken any IV or injectible drugs in the past year? ❑ Yes ❑ No

If yes, are you still taking it? ❑ Yes ❑ No

 Name:_____

EXPLAIN 'YES' ANSWERS TO ANY OF THE ABOVE QUESTIONS WITH COMPLETE DETAILS ATTACH ADDITIONAL SHEET IF NECESSARY

Question Number	Person's Name	Name of Condition	Currently Being Treated	Date of Onset	Date Last Treated	Date of Last Hospitalization	Total # of Days in Hospital	Number of Hospital Stays

10. Are you, or any of your dependents, taking or have taken prescription drugs in the last year?. . . . . ❑ Yes ❑ No

Please list the drug, dosage and for whom:

Person's Name	Drug Name	Name of Condition	Currently taking?	How many per day	Dosage
			❑ Yes ❑ No		
			❑ Yes ❑ No		
			❑ Yes ❑ No		
			❑ Yes ❑ No		
			❑ Yes ❑ No		
			❑ Yes ❑ No		

You are not required to disclose the performance of or results of a test to determine the presence of the HIV antibody or other bloodborne pathogen performed on (1) a criminal offender or crime victim as a result of a crime that was reported to the police; (2) a patient who received the services of emergency medical services personnel at a hospital or medical care facility; or (3) emergency medical services personnel who were tested as a result of performing emergency medical services.

E. DEFINED TERMS

The term "emergency medical services personnel" includes:

(1) an individual employed or receiving compensation to provide out-of-hospital emergency medical services such as a firefighter, paramedic, emergency medical technician, licensed nurse, rescue squad person, or other individual who serves as an employee or volunteer of an ambulance service as defined by state law or a member of an organized first responder squad that is formally recognized by a political subdivision in the state, who provides out-of-hospital emergency medical services during the performance of the individual's duties;

(2) an individual employed as a licensed peace officer under state law;

(3) an individual employed as a crime laboratory worker while working outside the laboratory and involved in a criminal investigation;

(4) any individual who renders emergency care or assistance at the scene of an emergency or while an injured person is being transported to receive medical care and who is acting as a good samaritan as described under state law; and

(5) any individual who, in the process of executing a citizen's arrest as defined by state law may have experienced a significant exposure* to a source individual.*

The term **"blood-borne pathogen"** means pathogenic microorganisms that are present in human blood and can cause disease in humans. These pathogens include, but are not limited to, hepatitis B virus (HBV), hepatitis C virus (HCV), and human immunodeficiency virus (HIV).

The term **"source individual"** means an individual, living or dead, whose blood, tissue, or potentially infectious body fluids may be a source of blood-borne pathogen exposure to an emergency medical services personnel. Examples include, but are not limited to, a victim of an accident, injury, or illness or a deceased person.

The term **"significant exposure"** means contact likely to transmit a blood-borne pathogen, in a manner supported by the most current guidelines and recommendations of the United States Public Health Service at the time an evaluation takes place, that includes: (1) percutaneous injury, contact of mucous membrane or nonintact skin, or prolonged contact of intact skin; and (2) contact, in a manner that may transmit a blood-borne pathogen, with blood, tissue, or potentially infectious body fluids.

F. EMPLOYEE AUTHORIZATION & REPRESENTATION

Read this section, date and sign the form.

On behalf of myself and anyone enrolled on or added to this form ("Us"), I authorize any hospital, clinic, institution, physician, insurance company, employer or other person to give Medica or any of its designees any and all records or information pertaining to medical history or services rendered to Us. I understand that this information will be used for underwriting, risk rating, enrollment or eligibility for benefits. I understand that in certain circumstances Medica may disclose the information collected to third parties without authorization and that the individuals enrolled on or added to this form have the right to see and correct their personal information in accordance with applicable law. I understand that I have the right to review Medica's Privacy Notice before signing this form and to request a copy at any time. I authorize on behalf of Us the use of a Social Security Number for the purpose of identification. The information provided on this form is accurate and complete, to the best of my knowledge and/or belief. I understand and agree that any omissions or incorrect statements knowingly made by Us on this form may invalidate my or my dependent's coverage. I understand that I may revoke this authorization by notifying Medica in writing. If I revoke the authorization, it will not affect any actions already taken by Medica prior to Medica's receipt of the revocation. If I refuse to sign this authorization, it will affect my dependents' and my eligibility and enrollment for benefits. I understand that I may request a copy of this completed authorization form. Information used or disclosed pursuant to this authorization will remain subject to Medica's privacy standards.

For North Dakota and South Dakota residents: For purposes of facilitating enrollment, unless revoked, this authorization permits Medica to obtain information about Us for 24 months from the date of signature.

For Minnesota residents: For purposes of facilitating enrollment, unless revoked, this authorization permits Medica to obtain information about Us from the date of signature until termination of our coverage.

This authorization does not extend to a release concerning the performance of, or results of, a test to determine the presence of the HIV antibody or other bloodborne pathogen* performed on (1) a criminal offender or crime victim as a result of a crime that was reported to the police; (2) a patient who received the services of emergency medical services personnel* at a hospital or medical care facility; or (3) emergency medical services personnel who were tested as a result of performing emergency medical services.

For Wisconsin residents: For purposes of facilitating enrollment, unless revoked, this authorization permits Medica to obtain information about Us for 30 months from the date of signature.

I understand that providing false information or omission of relevant information in this form may result in the denial of claims or cancellation or retroactive termination of coverage.

Employee Signature: **X** _____ Date Signed: _____

Discrimination is Against the Law

Medica complies with applicable Federal civil rights laws and will not discriminate against any person on the basis of race, color, national origin, age, disability or sex. Medica:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: TTY communication and written information in other formats (large print, audio, other formats).
- Provides free language services to people whose primary language is not English, such as: Qualified interpreters and information written in other languages.

If you need these services, call the number included in this document or on the back of your Medica ID card. If you believe that Medica has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Civil Rights Coordinator, Mail Route CP250, PO Box 9310, Minneapolis, MN 55443-9310, 952-992-3422 (phone/fax), TTY 711, civilrightscoordinator@medica.com.

You can file a grievance in person or by mail, fax, or email. You may also contact the Civil Rights Coordinator if you need assistance with filing a complaint.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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Nếu quý vị muốn giúp dịch tài liệu này miễn phí, gọi 1-800-952-3455.

Sanadnikun kaffaltiimaleeakkaisiniifhiikamuyoobarbaadd-an 1-800-952-3455 tiinbilbilaa.

إذا كنت ترغب في مساعدة مجانية لترجمة هذا المستند، فاتصل على الرقم1-800-952-3455.

Если вы хотите получить бесплатную помощь в переводе этого документа, позвоните по телефону 1-800-952-3455.

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