mda health plan
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Enrollment Form

Thank you for choosing the MDA Health Plan. Please complete this form for yourself and any dependents you wish to cover. A few reminders to help you complete this form:

- Please print clearly using blue or black ink.
- ALL sections of this form must be completed in order to process coverage for you and your family. If it is not complete and accurate, the form will be sent back to you, and this will cause a delay in processing coverage for you and your family.
- Qualifying events for mid-year changes are outlined in the Summary Plan Document. Changes must be submitted within 30 days of the qualifying event and documentation must be provided.
- If you have any questions or need assistance while completing this form, please call 1-877-906-9924 and press 1.

Employee Information

Employee Name *(last, first, initial)*		**Social Security Number**	**Home Phone**
Date of Birth *(month/day/year)*	**Gender** ☐Male ☐Female	**Marital Status** ☐Single ☐Married ☐Widowed ☐Divorced	**Mobile Phone**
Street Address		**City**	**ZIP Code**
Email Address			

Medical Coverage

Medical coverage is offered through the MDA Health Plan.

Effective Date	**Medical Coverage Tier** ☐Employee Only ☐Employee + 1 ☐Family

Medical Plan Selection

☐ Simply Copays (0) ☐ Premier Elite PPO (1) ☐ Elite PPO (2) ☐ Select PPO (3) ☐ Classic Plus PPO (4) ☐ Elite HSA (5)
☐ Family Focus HSA (6) ☐ Family Focus PPO (8) ☐ Advanced Value Plan (10) ☐ Living Fit PPO (11) ☐ Living Fit HSA (12)

Employee Signature	**Today's Date**

Employer Information (to be completed by employer)

Company Name	**Original Date of Hire**	**Date of Rehire (for rehires)**	**Hours Worked (per week)**
Company Street Address	**City**	**ZIP Code**	
Company Email Address	**Company Phone**	**EIN**	

Reason for Enrollment/Change

☐New Hire ☐Re-Hire ☐QMSCO * ☐Termination
☐New Group ☐Marriage* ☐Change of Employment Status ☐Address Change
☐Open Enrollment ☐Birth* ☐Loss of Coverage* ☐Name Change
☐Other _____

Employer Signature	**Today's Date**

Office Identifier ***(MDA office use only)***

**Documentation required*

Dependent Information (your spouse and/or each eligible child you wish to enroll)

Dependent 1

Dependent Name *(last, first, initial)*		**Relationship** ☐Spouse ☐Child ☐Step-Child ☐Other _____	
Date of Birth *(month/day/year)*	**Gender** ☐Male ☐Female	**Social Security Number**	**Phone Number**
Street Address *(if different than employee)*		**City**	**ZIP Code**

Dependent 2

Dependent Name *(last, first, initial)*		**Relationship** ☐Spouse ☐Child ☐Step-Child ☐Other _____	
Date of Birth *(month/day/year)*	**Gender** ☐Male ☐Female	**Social Security Number**	**Phone Number**
Street Address *(if different than employee)*		**City**	**ZIP Code**

Dependent 3

Dependent Name *(last, first, initial)*		**Relationship** ☐Spouse ☐Child ☐Step-Child ☐Other _____	
Date of Birth *(month/day/year)*	**Gender** ☐Male ☐Female	**Social Security Number**	**Phone Number**
Street Address *(if different than employee)*		**City**	**ZIP Code**

Dependent 4

Dependent Name *(last, first, initial)*		**Relationship** ☐Spouse ☐Child ☐Step-Child ☐Other _____	
Date of Birth *(month/day/year)*	**Gender** ☐Male ☐Female	**Social Security Number**	**Phone Number**
Street Address *(if different than employee)*		**City**	**ZIP Code**

Dependent 5

Dependent Name *(last, first, initial)*		**Relationship** ☐Spouse ☐Child ☐Step-Child ☐Other _____	
Date of Birth *(month/day/year)*	**Gender** ☐Male ☐Female	**Social Security Number**	**Phone Number**
Street Address *(if different than employee)*		**City**	**ZIP Code**

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Authorization to release PHI

I _____, acknowledge that the MDA Insurance & Financial Group's Notice of Privacy Practices has been made available to me. I also hereby authorize MDA Insurance & Financial Group, Inc. to release my protected health information to the person(s) listed below (example: spouse, parent, grandparent, sibling, etc.):

_____ No person

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

MDA Insurance & Financial Group, Inc. may leave voicemail messages containing protected health information at the following phone number(s) and or email address:

_____ None

_____
E-mail address

Area Code	Phone number	Circle one: Home/Office/Cell
Area Code	Phone number	Circle one: Home/Office/Cell

_____ _____
Signature Date

This authorization will expire when my health insurance through MDA Insurance & Financial Group, Inc. ends or when I revoke this authorization in writing to:

MDA Insurance & Financial Group, Inc.
Health Insurance Department
3657 Okemos Road, Ste. 100
Okemos, MI 48864
877.906.9924 phone
517-484-5460 fax

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Authorization for Disclosure of Protected Health Information

I, _____, authorize the disclosure of my Protected Health Information as described herein. I understand that this authorization is voluntary. I understand that, if person(s) or organization(s) that I authorize to receive my Protected Health Information are not subject to federal and state health information privacy laws, subsequent disclosure by such person(s) or organization(s) may not be protected by those laws.

I authorize the following person(s) and or organization(s) to receive my Protected Health Information.

- The Health Plan Department at MDA Insurance & Financial Group
- Priority Health

I authorize the disclosure of Protected Health Information relating to the request to have a specific issue resolved, explained, or reprocessed.

I understand that I may revoke this authorization in writing at any time by sending a signed and dated written statement to the Health Plan Department MDA Insurance & Financial Group that I am revoking my authorization to disclose health records, except to the extent that the person(s) and/or organization(s) named above have taken action in reliance on this authorization.

I further understand that my eligibility for health benefits, my enrollment in a health plan, and my treatment will not be affected by whether or not I sign this authorization. The consequences for my refusal to sign this authorization may result in my being in eligible for assistance in resolving, explaining or the reprocessing of a specific issue.

I have had the opportunity to read and consider the contents of this authorization. I confirm that the contents are consistent with my direction.

Signed _____ Date_____

Name_____

Address_____

Telephone_____ SS#_____

Protected Health Information (PHI) is health information that is created by a health care provider, health plan, or health care clearinghouse, which relates to: (1) the past, present, or future physical or mental health of an individual; (2) the provision of health care to an individual; or (3) the past, present, or future payment for the provision of health care to an individual. To be protected, the information must be such that it identifies the individual or provides a reasonable basis to believe that the information can identify the individual.

These laws apply to health plans, health care providers, and health care clearinghouses.

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Notice of Electronic Disclosure

If you have a work or home e-mail address, you will receive your MDA Health Plan information electronically.

How it works:

- When you consent to electronic disclosure, you will receive an e-mail notification when new Employee Benefits notices have been posted.
- Benefit notices including newsletters, enrollment announcements, Summary Plan Descriptions (SPDs) and plan amendments will be posted at: https://www.mdaprograms.com.
- To view the notices, you can go directly to the internet location above, or simply click the links provided in your notification e-mail.

Prior to consenting, you should understand:

- **Signature required:** To receive Employee Benefit notices electronically, you must sign this form below.
- **Access:** If you do not have access to the Internet and a printer, you should not consent.
- **SPD:** Each benefit plan has a Summary Plan Description (SPD), which describes the major components of your plan.
- **Amendments:** Plan amendments describe changes made to your benefit plan. A plan's SPD and plan amendments are important documents.
- **Cancellation:** You have the right to withdraw your consent to electronic distribution at any time at no charge. To withdraw consent, you must provide notification via mail to the address below or via fax to 517-484-5460.

  Health Plan Department
  MDA Insurance & Financial Group
  3657 Okemos Road, Suite 100
  Okemos MI, 48864

- **Flexibility:** If you consent to electronic distribution, you may still request a paper version of any document free of charge.

I agree to electronic delivery MDA Health Plan information. Please use the email address indicated below. I understand that I may revoke or change my consent at any time without charge and that I am entitled to request and obtain a paper copy of any electronically furnished documents free of charge.

*Email Address:*_____

*Printed Name:*_____

*Employer Name:*_____

*Signature:*_____ *Date:*_____