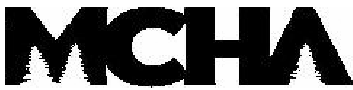

ADDRESS CHANGES DEPENDENT ADDITIONS

Send completed form to:
MCHA/Medica, Mn015-2838
4316 Rice Lake Road
Duluth, MN 55811

A. Enrollee Information (Required) – Minnesota Comprehensive Health Association (MCHA)

1. Last Name of MCHA Enrollee	2. First Name	3. MI	4. Group #	5. ID # (from your MCHA ID Card)

6. If enrollee is a minor child, please list parent(s) or legal guardian(s)	7. Enrollees Birth Date (mm/dd/yy)

8. Home Telephone	9. Work Telephone	10. E-Mail

B. Enrollee Address Changes

11. Residence Address: Number and Street City State Zip

12. Optional Address Information (**only if different from residence address above**)
Billing Address
In Care of: Number and Street City State Zip

Claims/EOB Correspondence Address
In Care of: Number and Street City State Zip

C. Dependent Additions

Newly eligible dependents can be added if: A) Newborn as of the date of birth; B) Dependent child placed for adoption as of date of placement. We encourage enrollment within 30 days (<u>attached copy of the adoption placement papers</u>); C) New legal spouse as of date of marriage if added within 30 days of the date of marriage (<u>attach marriage certificate</u>).
List dependents below and attach an additional sheet if necessary to this form.

13. Requested date of change (if approved, coverage begins at 12:01 a.m. on the effective date) ______/______/______

Dependent(s) Full Name	Gender (M) (F)	Birth date (mm/dd/yy)	Social Security Number
Name: Address (if different):			
Name: Address (if different):			
Name: Address (if different):			
Name: Address (if different):			

14. My spouse (if seeking MCHA coverage) has used tobacco or tobacco cessation products in the past 12 months: ☐ Yes ☐ No
15. My dependent(s) (if they are seeking MCHA coverage) are residents of Minnesota. ☐ Yes ☐ No

D. Enrollee Authorization & Representation – Read this section, date and sign the application

On behalf of myself and anyone enrolled on or added to this application ("Us"), I authorize any health care professional or entity to give MCHA/Medica or any of its designees any and all records or information pertaining to medical history or services rendered to Us. I further consent, on behalf of Us, to MCHA's/Medica's use and discloser of protected health information for routine purposes, including payment, treatment and health care operations, described in the MCHA Privacy Notice. MCHA/Medica may use and disclose our protected health information for routine purposes for as long as necessary in connection with the coverage provided to Us. For purposes of facilitating enrollment this consent also authorizes MCHA/Medica to obtain information about Us for as long as MCHA continually insures Us. I understand that I have the right to request restrictions on the use or disclosure of protected health information. MCHA/Medica is not required to agree to any such restrictions, but if it does agree, MCHA/Medica will abide by the terms of the restrictions. I understand that I have a right to review the Privacy Notice before signing this form. I also understand that MCHA/Medica reserves the right to change its Privacy Notice, in which case I will be provided with a revised Privacy Notice. This authorization does not extend to a release concerning the performance of, or results of, a test to determine the presence of HIV antibody or other bloodborne pathogen. I also authorize on behalf of Us the use of a Social Security Number for the purposes of identification. The information provided on this application is accurate and complete. I understand and agree that any omissions or incorrect statements knowingly made by Us on this application may invalidate my and/or my dependents' coverage.

X___________________________________ _________ X___________________________________ _______
Signature of Enrollee Date Signature of Parent (if enrollee is under age 18) Date