Montana Large Employer 51+
ENROLLMENT APPLICATION

Montana Food Distributors Association
"Promoting and Protecting the Grocery Industry of Montana"
Since 1939

Employer Group Name:

1. Employee Information		
Employee Last Name	First Name	M.I.
Mailing Address	City	State, Zip
Home Phone	Email	Job Title
Gender ☐ Male ☐Female	Marital Status ☐ Married ☐Single ☐ Domenstic Partner - if checked are you registered? ☐ Yes ☐ No If yes, State_____?	
Are you an active employee? ☐Yes ☐ No If yes, compete Section 2.		
Type of New Enrollment I am ☐ New Employee ☐ Adding dependent, spouse, partner, or child Date of qualifying event:_____ Attach proof of event		
☐ Foster	☐ Marriage	☐ Domestic Registration or Affidavit ☐ Birth
☐ Adoption	☐ Court Order	☐ Involuntary loss of other group coverage
☐ Late enrollment or open enrollment (see disclosure for more information).		

2. Employee and Family Members You Wish to Enroll				
Name	*Sex*	*Birth Date*	*Social Security Number - Required Section 111 of Public Law 110-173*	*Coverage*
Employee				☐ Medical ☐ Dental ☐ Vision
Spouse or Domestic Partner				☐ Medical ☐ Dental ☐ Vision
Dependent Child				☐ Medical ☐ Dental ☐ Vision
Dependent Child				☐ Medical ☐ Dental ☐ Vision
Dependent Child				☐ Medical ☐ Dental ☐ Vision
Dependent Child				☐ Medical ☐ Dental ☐ Vision
Dependent Child				☐ Medical ☐ Dental ☐ Vision

If you or your spouse/domestic partner are a court-ordered guardian of any dependent listed above, identify and provide proof:
Name(s):_____ Grandchild Niece/Nephew Sibling Foster Other:_____

Tobacco Users-Has anyone on this application used tobacco an average of 4 or more times a week in the last 6 months? ☐Yes ☐No

Name(s)	In a tobacco cessation program? ☐Yes ☐No If yes, list details Name of Program: Date began:	If Native American/Alaska Native, is use for religious or ceremonial purposes? ☐Yes ☐No

3. Other Coverage

Married or Partner - is your spouse or domestic partner employed? ☐Yes ☐No If yes, self employed? ☐Yes ☐No

Medicare - If you or any person on this application has Medicare, indicate coverage: ☐Part A ☐Part B ☐Part D

Name	Original Effective Date	Medicare No. *(include alpha prefix)*	Reason for Medicare entitlement

4. Child Custody Information

If you are enrolling children of a previous relationship, you must complete this section. Also, list court ordered coverage in Other Coverage section above. Regulations require plan information to be provided to the custodial parent.

Child's Name	Whose Child	Joint Custody	Custodial Parent Name	Custodial Parent Address	Custodial Parent Phone #	Name Responsible for Insurance *(court order)*
	☐ Yours ☐ Spouse	☐ Yes ☐ No				
	☐ Yours ☐ Spouse	☐ Yes ☐ No				

5. Diagnosis and Treatment Disclosure

Please list current height and weight for all persons to be covered

Name	Height	Weight	Name	Height	Weight

Please indicate if anyone on this application has been diagnosed with or treated for any of the following conditions. Omit information regarding genetic tests, results of such tests, or any family medical history (other than requested below) that may indicate a genetic predisposition to any disease or disorder. This information will be kept confidential and is requested for quoting and enrollment purposes only. If additional space is needed to provide complete information, please use a separate sheet that is signed and dated.

Autoimmune Disorders & Diseases of Blood:	Cancer, Tumor, Leukemia:	Circulatory:	Digestive:	Genetic Endocrine, Nutritional or Metabolic:
☐ Coagulation disorder ☐ HIV, AIDS, AIDS related complex ☐ Lupus ☐ Rheumatoid arthritis ☐ Other (please list below)	☐ Benign ☐ Malignant If yes, please list type and location below.	☐ Aneurysm ☐ Angina ☐ Congestive heart failure ☐Heart attack, Myocardial infarction ☐ Heart disorder ☐ Stroke, TIA ☐ Valve disorder	☐ Celiac sprue ☐ Colon disorder ☐ Colostomy ☐ Crohn's ☐ Gastric bypass ☐ Hepatitis C ☐ Liver disorder ☐ Stomach disorder	☐ Diabetes Type I or II ☐ Genetic/chromosomal disorder ☐ Metabolic syndrome ☐Pituitary disorders, dwarfism, hormonal imbalances ☐ Thyroid, except hypothyroid
Genitourinary:	**Mental Disorders:**	**Musculoskeletal:**	**Nervous System:**	**Respiratory:**
☐ Bladder disorder ☐ Infertility ☐ Kidney disorder ☐Prostate ☐ Reproductive organs ☐Urinary tract disorder	☐ Anxiety, Depression, PTSD, OCD ☐ Bipolar, Schizophrenia ☐ Eating, including anorexia or bulimia ☐ Substance abuse ☐ Suicide attempt	☐ Arthritis ☐ Back disorder ☐ Fracture of ankle, wrist, spine or pelvis ☐ Joint disorder ☐ Neck disorder ☐ Osteoporosis ☐ Scoliosis, if under 21	☐ ALS, Lou Gehrig's disease ☐Multiple sclerosis ☐ Parkinson's ☐ Seizure disorder, epilepsy ☐ Other (list below)	☐ Asthma ☐ Emphysema ☐ Lung, respiratory disorder ☐ Pulmonary hypertension ☐ Sleep apnea

Signs and Symptoms:	Has any person on this application received or been recommended to receive any medical treatment not listed above, been fitted with implants or orthopedic devices, or used durable medical equipment? ☐Yes ☐No If yes, please describe below:
☐ Artificial opening, other than colostomy ☐ Congenital defects; cleft palate; heart malformation, congenital hip dislocation ☐ Headaches, migraines ☐ Premature birth if within 5 years ☐ Transplant; except cornea	If any of the conditions were marked in this section, provide additional details below:

Have you or any person listed on this application for coverage accrued $10,000 or more in medical bills in the past 12 months?
☐ Yes ☐ No If yes, please list name of person.

Condition details and/or medications: Please use the space below to explain any conditions checked above and/or list any medications taken by any person listed for benefits coverage on this application within the last 5 years.

Name	Nature of illness, disability, or medication	Daily Dosage	List of Treatment(s)	Onset Date

Does any family member, whether applying or not, have reason to believe that she or he is an expectant mother of father positive results of ahome pregnancy test, or laboratory results? ☐Yes ☐No If yes, complete the following:

Name of Person(s):_____

Due Date(s):_____ Fetus: ☐One ☐Multiple

Any complications? ☐Yes ☐No If yes, explain_____

6. Electronic Communications

You affirmatively consent to the following: (1) to submit your application for enrollment on a group plan filed electronically over a secured internet connection, (2) your electronic submission has the same force and effect as if you had submitted a paper application to PacificSource with your signature with PacificSource Health Plans on behalf of the MFDA Plan (PacificSource), (3) to receive secured electronic communications from PacificSource regarding your application and/or enrollment status, and (4) to keep PacificSource informed of your current e-mail address that it may use to correspond with you. You also agree to receive summary plan descriptions (SPDs) and other notices and forms related to the plan through electronic communication.

You may, at any time, opt out of these electronic communications or request a free paper copy of your application and/or enrollment information by contacting our Membership Department at membership@pacificsource.com, or toll-free at 866.999.5583. Electronic communications are offered as a convenience only and your decision not to receive electronic communications will not affect your enrollment and there is no charge associated with switching to paper. PacificSource highly recommends you keep a copy of your application and any associated materials.

In order to complete the application electronically, you must have a personal computer or other device capable of accessing the internet and the ability to view and revise Portable Document Format (PDF) files. You can obtain a free copy at http://get.adobe.com/reader/. PacificSource takes the security of electronic information and communications seriously. If you have any questions about our encryption, technical hardware or software, or our security policies and procedures, please contact us at membership@pacificsource.com.

7. Acknowledgment and Declaration

I acknowledge and understand that my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on this enrollment form) from time to time for the purpose of facilitating healthcare treatment, payment, or for business operations necessary to administer healthcare benefits; or as required by law. Please see the notice of privacy practices for more information.

Health information requested or disclosed may be related to treatment or services performed by: A physician, dentist, pharmacist, or other physical or behavioral healthcare practitioner; A clinic, hospital, long term care, or other medical facility; Any other institution providing care, treatment, consultation, pharmaceuticals or supplies, or: An insurance carrier or group health plan.

Information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billings, diagnostic imaging reports, laboratory reports, or dental or hospital records (including nursing records and progress notes).This acknowledgment does not apply to obtaining information regarding psychotherapy notes, which uses a separate authorization.

I affirm the answers given in this application are complete and correct. All people on this application age 18 or over must sign below

Employee:_____ Date:_____ Spouse:_____ Date:_____

Dependent:_____ Date:_____ Dependent_____ Date:_____