Primary Applicant's Name:

MEDICA®

Medica Individual and Family Plans

Thank you for applying for a Medica health plan!

MINNESOTA TWIN CITIES METRO APPLICATION FORM

General Medica policy information

- This application will issue an individual/family policy only.
- Primary applicants under age 21 are not eligible for a family policy.
- Your Social Security Number will be used for the purpose of identification only.
- Online applications are available at **medica.com**. Applying online may reduce your application's processing time.
- You may be able to receive a cost sharing subsidy and/or premium tax credit. To see if you're eligible, please visit **www.mnsure.org**.

Completing your application

- Complete all sections within the application thoroughly and accurately. Applications with missing or inaccurate information will be delayed in processing. Unless otherwise indicated, all requested information must be provided for your application to be considered complete.

Submitting your application

- Your application cannot be processed unless it is submitted with the full first month's premium payment.
- Please complete, sign, and date your application and fax or mail to Medica. All adults, including dependents age 18 and over, must sign. For Medica Applause, North Memorial Acclaim by Medica, or Inspiration Health by HealthEast and Medica policies, if the primary applicant is under age 18, a guarantor, parent, or legal guardian must provide a signature.
- See Section F for information on your effective date. Medica will notify you regarding the effective date of coverage. The processing time for your application is approximately five to seven business days. **Do not cancel any existing coverage until the Medica policy is issued and accepted by you**.
- Make a copy of your completed application for your personal records. This copy will become a part of your contract.

Contact us if you have questions

Please contact Medica Inside Sales at 952-992-2080 or 1-800-670-5935 between 8:00 a.m. and 5:00 p.m., Monday through Thursday, and 9:00 a.m. and 5:00 p.m. on Friday.

SECTION A CURRENT MEDICA MEMBERSHIP STATUS

❑ I am a new applicant not currently covered under a Medica policy.

❑ I currently have Medica coverage and I want to switch to a different Medica plan.

I am covered under Medica I.D. number:

If your current Medica policy is through your employer, please indicate your employer's name:

❑ I currently have a Medica Individual and Family plan and want to add the dependent(s) I've listed in Section B.

I am covered under Medica I.D. number:

Would you like to keep your current plan? . . . . ❑ Yes ❑ No
If Yes, do not complete Section C.

SECTION B

APPLICANT INFORMATION

Primary applicant *(if you are applying on behalf of a minor, indicate their name here)*

Last name	First name	Middle initial

Parent/guardian *(only if applying on behalf of a minor)*

Last name	First name	Middle initial

Applicant's home address

Street

City	State	Zip Code	County

Applicant's billing address *(if different than home address)*

Street

City	State	Zip Code

Marital status	Preferred telephone number	
❑ Single ❑ Married ❑ Domestic Partnership	___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___	Best time to call: ❑ Morning ❑ Afternoon ❑ Evening

Mailing preference

Please send all mail (other than billing statements) such as my enrollment packet, ID cards and claims information to:

❑ Home address ❑ Billing address

List each person applying for coverage. Add additional pages if necessary.

#	First name Middle initial Last name		Birth date (mo/day/yr)		Race (optional)	Ethnicity (optional)
1	*(Primary applicant)*	Social Security No.		Sex: M F	❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian or other Pacific Islander ❑ White ❑ Other	❑ Hispanic or Latino ❑ Not Hispanic or Latino
2	Relationship to applicant	Social Security No.		Sex: M F	❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian or other Pacific Islander ❑ White ❑ Other	❑ Hispanic or Latino ❑ Not Hispanic or Latino

continues next page…

SECTION B

APPLICANT INFORMATION CONTINUED

List each person applying for coverage. Add additional pages if necessary.

3

First name Middle initial Last name | Birth date (mo/day/yr)

Relationship to applicant | Social Security No. | Sex: M F

Race (optional):
- ❑ American Indian or Alaska Native
- ❑ Asian
- ❑ Black or African American
- ❑ Native Hawaiian or other Pacific Islander
- ❑ White
- ❑ Other

Ethnicity (optional):
- ❑ Hispanic or Latino
- ❑ Not Hispanic or Latino

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First name Middle initial Last name | Birth date (mo/day/yr)

Relationship to applicant | Social Security No. | Sex: M F

Race (optional):
- ❑ American Indian or Alaska Native
- ❑ Asian
- ❑ Black or African American
- ❑ Native Hawaiian or other Pacific Islander
- ❑ White
- ❑ Other

Ethnicity (optional):
- ❑ Hispanic or Latino
- ❑ Not Hispanic or Latino

5

First name Middle initial Last name | Birth date (mo/day/yr)

Relationship to applicant | Social Security No. | Sex: M F

Race (optional):
- ❑ American Indian or Alaska Native
- ❑ Asian
- ❑ Black or African American
- ❑ Native Hawaiian or other Pacific Islander
- ❑ White
- ❑ Other

Ethnicity (optional):
- ❑ Hispanic or Latino
- ❑ Not Hispanic or Latino

6

First name Middle initial Last name | Birth date (mo/day/yr)

Relationship to applicant | Social Security No. | Sex: M F

Race (optional):
- ❑ American Indian or Alaska Native
- ❑ Asian
- ❑ Black or African American
- ❑ Native Hawaiian or other Pacific Islander
- ❑ White
- ❑ Other

Ethnicity (optional):
- ❑ Hispanic or Latino
- ❑ Not Hispanic or Latino

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First name Middle initial Last name | Birth date (mo/day/yr)

Relationship to applicant | Social Security No. | Sex: M F

Race (optional):
- ❑ American Indian or Alaska Native
- ❑ Asian
- ❑ Black or African American
- ❑ Native Hawaiian or other Pacific Islander
- ❑ White
- ❑ Other

Ethnicity (optional):
- ❑ Hispanic or Latino
- ❑ Not Hispanic or Latino

8

First name Middle initial Last name | Birth date (mo/day/yr)

Relationship to applicant | Social Security No. | Sex: M F

Race (optional):
- ❑ American Indian or Alaska Native
- ❑ Asian
- ❑ Black or African American
- ❑ Native Hawaiian or other Pacific Islander
- ❑ White
- ❑ Other

Ethnicity (optional):
- ❑ Hispanic or Latino
- ❑ Not Hispanic or Latino

Tobacco use

Have you or anyone on this application used tobacco products four or more times a week on average (other than for religious or ceremonial purposes) within the last six months? . . . . ❑ Yes ❑ No

If Yes, list all individuals:

SECTION C PLAN SELECTION

Note: Medica cannot process your application if your Plan Selection page is not completed. This page can be found as the last page of the application. If you are adding a dependent to your current plan during an open enrollment or a special enrollment period, you do not need to complete Section C.

SECTION D PAYMENT INFORMATION

Note: You can find your rate online at **medica.com**. Your initial payment should reflect the rate quoted online.

D1 First month payment *(first month payment must be submitted with this application)*

Choose payment method:	Amount paid with this application:
❑ Check *(make payable to Medica)* ❑ Credit Card *(submit with Credit Card Authorization Form)*	$

D2 Ongoing payments

Choose payment method:

❑ Check *(make payable to Medica)*
❑ ACH Automatic Payment from your checking account *(you must complete the ACH Authorization Form)*
❑ Credit Card *(you must complete the Credit Card Authorization Form – service fees may apply)*

SECTION E OTHER INSURANCE INFORMATION

1. Is any person named on the application covered by Medicare? . . . . ❑ Yes ❑ No
2. Would this coverage replace or change any existing health insurance? . . . . ❑ Yes ❑ No

If you answered Yes to a question above, please provide your current health coverage information by completing the insurance information below:

Coverage start date	Coverage end date	List all persons covered under policy	Name of insurance company	Type of insurance
				❑ Individual ❑ COBRA ❑ Group
				❑ Individual ❑ COBRA ❑ Group
				❑ Individual ❑ COBRA ❑ Group
				❑ Individual ❑ COBRA ❑ Group

SECTION F EFFECTIVE DATE OF COVERAGE

- Coverage must start on the 1st of any month.
- Applications are only accepted during the open enrollment period; applications received after will be denied enrollment unless they meet qualifying event criteria to enroll for a special enrollment period.
- If no effective date is indicated, your effective date would automatically be the next available effective date.

I'm requesting an effective date of	
Month:	Day: ❑ 1st

SECTION

G AUTHORIZATION AND REPRESENTATION

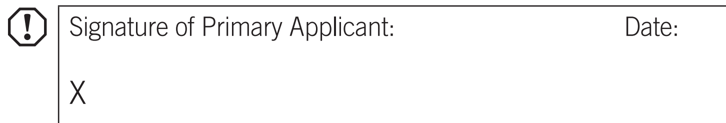
TO BE SIGNED BY APPLICANTS

I represent that the information provided herein is true and complete to the best of my knowledge and belief. I understand that Medica may rescind coverage back to the effective date of coverage for fraud and intentional material misrepresentation.

I understand that:

1. This information will be used for risk rating, enrollment or eligibility for benefits;
2. Medica may re-disclose the information without authorization as permitted by law, which means it may no longer be protected by privacy rules;
3. I may revoke this authorization in writing. Revocation will not affect any actions taken by Medica prior to Medica's receipt of the revocation. Unless revoked, this authorization will remain in effect for the term of my coverage;
4. Benefits under the policy will be based upon the selection made in Section C.
5. I have the right to see and correct my personal information in accordance with the law;
6. I have the right to review Medica's Privacy Notice before signing this application and to request a copy at any time.
7. I authorize Medica to release information related to my Medica enrollment to my insurance broker should I choose to name one. This includes information related to any applicant listed within this application.
8. I authorize Medica to disclose any information in its possession to any of my providers who will manage or coordinate my care.

Please keep a copy of your completed application for your records. If you are approved for coverage, this copy will become a part of your contract.



Signature of Primary Applicant: Date:

X

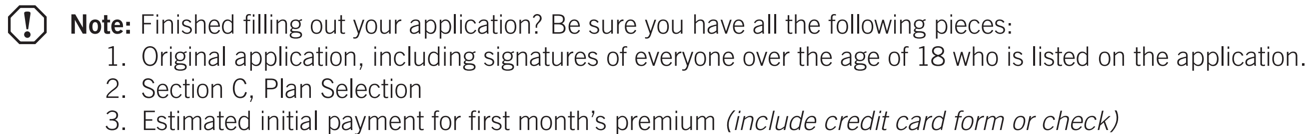
Please provide signature below if primary applicant is under age 18:

Signature of Parent or Legal Guardian: Date:

X

As an additional applicant named on this application, I authorize Medica to disclose my protected health information to the primary Applicant regarding this application.

Signature of Additional Applicant Age 18 or Older: Date:	Signature of Additional Applicant Age 18 or Older: Date:
X	X
Signature of Additional Applicant Age 18 or Older: Date:	Signature of Additional Applicant Age 18 or Older: Date:
X	X



Note: Finished filling out your application? Be sure you have all the following pieces:

1. Original application, including signatures of everyone over the age of 18 who is listed on the application.
2. Section C, Plan Selection
3. Estimated initial payment for first month's premium *(include credit card form or check)*

Additional items you may have to your application:

4. ACH form *(if you are enrolling in automatic payment from your checking account or credit card)*

Return completed applications to:
Medica Insurance Company
Mail Route CW295
PO Box 9310
Minneapolis, MN 55440-9310

or Fax to:
952-992-2511

SECTION H — AGENT USE ONLY

I certify that I have reviewed this application. If application was completed by agent, agent certifies that he/she personally completed this application, that each question was asked separately, that the answers recorded in this application are complete and accurate as given.

Signature of agent	Date	Agent number
X		

Print agent's name	Telephone number

SECTION I — FOR OFFICE USE ONLY

Date received	Policy effective date	Payment ID	Amount	Promo code

MEDICA PRIVACY NOTICE

Medica takes its responsibility of protecting your personal information seriously. Where possible, Medica de-identifies or encrypts personal information. We use and disclose personal information only to the extent necessary to conduct treatment, payment and health care operations, or to comply with legal, regulatory or accreditation requirements.

Medica and its business associates obtain, maintain, use and share personal information to carry out certain routine activities. Routine activities include: (i) treatment-related activities, such as referring you to a doctor or other provider; (ii) payment-related activities, such as paying a claim for medical services rendered; and (iii) health care operations, such as professional peer review.

The law also gives you rights to access, copy, and amend your personal information. You have the right to request restrictions on certain uses and disclosures of your personal information. You also have the right to obtain information about how and when your personal information has been used and disclosed.

Medica's full Privacy Notice is available upon request by calling 1-800-670-5935 or by going to www.medica.com.

MEDICA®

Mail Route CW295, PO Box 9310, Minneapolis, MN 55440-9310

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SECTION C PLAN SELECTION

1. Please select your network and complete the additional information below it. Visit **medica.com** to learn more about plan benefits.

	Inspiration Health by HealthEast and Medica SM ❑	**North Memorial Acclaim by Medica** SM ❑	**Medica Applause**SM ❑

2. Choose a metal level and plan type.

Metal level	Inspiration Health by HealthEast and Medica	North Memorial Acclaim by Medica	Medica Applause
GOLD 70% coverage	**One-Person Coverage** ❑ Copay Plan $100 deductible ❑ HSA Compatible Plan $1,300 deductible **Family Coverage** ❑ Copay Plan $300 deductible ❑ HSA Compatible Plan $3,900 deductible	**One-Person Coverage** ❑ Copay Plan $100 deductible ❑ HSA Compatible Plan $1,300 deductible **Family Coverage** ❑ Copay Plan $300 deductible ❑ HSA Compatible Plan $3,900 deductible	Gold metal level not available
SILVER 60% coverage	**One-Person Coverage** ❑ Copay Plan $2,200 deductible ❑ HSA Compatible Plan $1,300 deductible **Family Coverage** ❑ Copay Plan $6,600 deductible ❑ HSA Compatible Plan $3,900 deductible	**One-Person Coverage** ❑ Copay Plan $2,200 deductible ❑ HSA Compatible Plan $1,300 deductible **Family Coverage** ❑ Copay Plan $6,600 deductible ❑ HSA Compatible Plan $3,900 deductible	**One-Person Coverage** ❑ Copay Plan $2,200 deductible ❑ HSA Compatible Plan $1,300 deductible **Family Coverage** ❑ Copay Plan $6,600 deductible ❑ HSA Compatible Plan $3,900 deductible
BRONZE 100% coverage	**One-Person Coverage** ❑ Copay Plan $6,350 deductible ❑ HSA Compatible Plan $6,300 deductible **Family Coverage** ❑ Copay Plan $12,700 deductible ❑ HSA Compatible Plan $12,700 deductible	**One-Person Coverage** ❑ Copay Plan $6,350 deductible ❑ HSA Compatible Plan $6,300 deductible **Family Coverage** ❑ Copay Plan $12,700 deductible ❑ HSA Compatible Plan $12,700 deductible	**One-Person Coverage** ❑ Copay Plan $6,350 deductible ❑ HSA Compatible Plan $6,300 deductible **Family Coverage** ❑ Copay Plan $12,700 deductible ❑ HSA Compatible Plan $12,700 deductible

Additional plan options for individuals and families **through age 29.**

Metal level	Inspiration Health by HealthEast and Medica	North Memorial Acclaim by Medica	Medica Applause
CATASTROPHIC 100% coverage	**One-Person Coverage** ❑ $6,350 deductible **Family Coverage** ❑ $12,700 deductible	**One-Person Coverage** ❑ $6,350 deductible **Family Coverage** ❑ $12,700 deductible	**One-Person Coverage** ❑ $6,350 deductible **Family Coverage** ❑ $12,700 deductible

Note: Catastrophic plan is not available as a child only policy. Primary applicants must be between the ages of 21–29.

هذه المعلومات إتصل بالرقم الموجود على ظهر بطاقة
اذا كنت تحتاج مساعدة مجانية في ترجمة هذه المعلومات
التعريف الطبية الخاصة لك Medica

Haddii aad doonayso in Af Soomaali laguugu tarjamadda macluumaadkani, oo lacag la'aan ah, Fadlan wac Lambarka ku qoran Kaarka Caafimaadka ee Medica dhabarkiisa.

Ako zelite besplatano tumacenje ovih informacija posovite broj na pozadini vase Medica kartice.

Yog koj xav tau kev pab txhais cov ntaub ntawv no dawb, hu rau tus xov tooj nyob nram qab koj daim Medica Khaj (card).

ຖ້າທ່ານຕ້ອງໃຫ້ຊ່ວຍແປຫນັງສື ຫຼືຂໍ້ມູນເຫຼົ່ານີ້ ຈົ່ງ ໂທຣຕາມເລກໂທຣສັບ
ທີ່ໃຫ້ໄວ້ຢູ່ຂ້າງຫຼັງ ເມດິກາ ຫຼືບັດ ກວດສຸຂພາບ7ງ່ຳກຣແ້8Medica

Yoo odeeyssi kun bilashitti afaan keetitti akka sii hiikamu feete lakkoofsa caaardiii meedikaa (Medica) gama dubaarra jiru kana bilbili.

Если вам нужна помощь в переводе этой информации, позвоните по номеру, указанному на обратной стороне вашей медецинской карточки плана Medica.

ប្រសិនបើអ្នកចង់បានការជួយបកប្រែដោយឥតគិតថ្លៃពីពត៌មាននេះ
សូមទូរស័ព្ទទៅលេខទូរស័ព្ទ នៅខាងខ្នងនៃកាតមេឌីកា Medica ។

Si usted desea ayuda gratuita para traducir esta información, llame al número de teléfono situado al reverso de su tarjeta de identificación de Medica.

Nếu quý vị muốn được giúp đỡ dịch tài liệu này miễn phí, xin gọi số ghi ở mặt sau thẻ Medica cũa quý vị.

Dine k'ehji shich'i' hadoodzih ninizingo, beesh bee hane'e binumber naaltsoos bikaahigii bich'i' hodiilnih ei doodaii bee neehozin biniiye nanitinigii bine'dee bikaa doo aldo'.

Para sa tulong sa Tagalog, tawagan ang numerong kabilang sa dokumentong ito o sa likod ng iyong ID card.

若需要中文协助，请拨打本文件内或您会员卡背面的电话号码。

UNV1011

If you want free help translating this information, call the number on the back of your Medica identification card.