MEDICA®

MINNESOTA

Medica Solo℠

Medica Encore℠

Application Form

Medica Solo℠ and Medica Encore℠ provide benefits for prenatal care services.

Medica Solo℠ and Medica Encore℠ do not cover maternity care services which include maternity labor and delivery services, and post partum care services.

Medica Insurance Company
MN-S&ECMB-AP 09-100-00

Medica Insurance Company
Mail Route CP320
PO Box 9310
Minneapolis, MN 55440-9310

IMPORTANT INFORMATION ABOUT YOUR APPLICATION

- ❑ Please review your application to assure that every question has been completed and thoroughly answered.
- ❑ To avoid unnecessary delays, please provide a complete explanation of all "Yes" answers in the space provided under Section E7. Please indicate whether any checkups, physicals, exams, lab work, or X-rays you've listed were routine or due to medically diagnosed conditions. Also indicate if the results were normal or if any problems were noted. For each medical condition, illness, or injury, include both the onset date and the complete recovery date when appropriate.
- ❑ See Section C3, for information on your effective date. Medica will notify you if you have been approved and your effective date. Processing time of your application is approximately 3 to 4 weeks. Do not cancel any existing coverage until the Medica policy has been approved, issued and accepted by you.
- ❑ Submit your premium payment along with your application. If the full first month's premium payment is not received, your application cannot be processed.
- ❑ Please complete, sign and date your application and mail to Medica in the enclosed postage-paid envelope. If the applicant is under age 18, the guarantor signature must be completed. Your enrollment form is valid for a period of 60 days from the date you sign it. After 60 days a new application must be completed in full.
- ❑ Please be sure to indicate the deductible you are applying for in Section B.
- ❑ You are not required to disclose the results of a test to determine the presence of the human immunodeficiency virus (HIV) antibody performed on a criminal sex offender or a crime victim who was exposed to or had contact with an offender's bodily fluids during commission of a crime that was reported to law enforcement. Additionally, you are not required to disclose the results of a test to determine the presence of a bloodborne pathogen* performed on the following individuals when a significant exposure* may have occurred: (1) an emergency medical services person* or source individual* at a hospital or freestanding emergency medical care facility; or (2) a corrections employee or source inmate at a correctional facility; or (3) an employee of a secure treatment facility or source patient at a secure treatment facility.

ANY MISSING INFORMATION WILL CAUSE DELAYS IN THE PROCESSING OF YOUR APPLICATION AND MAY RESULT IN RESCISSION OF YOUR POLICY.

If you have questions or need assistance completing this application, please contact a Medica Sales Service Specialist at 952-992-2080 or 1-800-670-5935 between 8:00 a.m. to 5:00 p.m., Monday through Thursday, and 9:00 a.m. to 5:00 p.m. on Friday.

Thank you for your interest in Medica.

* DEFINED TERMS: The term "emergency medical services person" includes (1) individuals 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 Minnesota 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 Minnesota 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 Minnesota law; and (5) any individual who, in the process of executing a citizen's arrest as defined by Minnesota law, may have experienced a significant exposure* to a source individual*.

The term "bloodborne 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 bloodborne pathogen exposure to an emergency medical services person. 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 bloodborne 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 bloodborne pathogen, with blood, tissue, or potentially infectious body fluids.

PLEASE TYPE or PRINT CLEARLY
USING BLUE OR BLACK INK.

Medica Solo℠ and Medica Encore℠

APPLICATION FORM

A. APPLICANT INFORMATION

1) Applicant's name (*Last, First, Middle*)

2) Marital status
❑ Single ❑ Married ❑ Widowed
❑ Divorced ❑ Separated

3) If applicant is a minor child, please list parent(s) or legal guardian(s)

4) Applicant's home address *Street*	*City*	*State*	*ZIP*	*County*
5) Billing address *(if different from #4)* *Street*	*City*	*State*	*ZIP*	*County*

6) E-mail address	7) Home telephone no. ( )	8) Cellular telephone no. ( )	Best time to call: ___ A.M. ___ P.M.

9) Please indicate your current eligibility status:
❑ I was born in the United States
❑ I am a legal U.S. citizen under Naturalization
❑ I have been a permanent U.S. citizen for at least one year (with a Green Card)
❑ Other:

10) Are you a permanent resident of Minnesota currently residing in Minnesota? . . . . . ❑ Yes ❑ No
If "No," please explain:

11) Occupation	Company name

Self employed? ❑ Yes ❑ No	Work telephone no. ( )	Hours worked per week _____ ❑ Full time ❑ Part time	Covered by Worker's Compensation? ❑ Yes ❑ No

Duties	12) Social Security Number	13) Birth date *(mo/day/yr)*	14) State of birth

15) Sex ❑ Male ❑ Female	16) Height ft. in.	17) Present weight lbs.	18) Weight one year ago lbs.

19) Reason for application *(check one)*:
❑ I am a new applicant presently not covered under a Medica policy.
❑ I presently have Medica coverage. I am covered under I.D. number: |_|_|_|_|_|_|_|_|_|_|_|_|_|_|

B. BENEFIT SELECTION (select either Solo or Encore and complete the correct section)

❑ Medica Solo℠

1) Select your plan's deductible level:
100% Plan
❑ $3,150 Deductible Coverage
❑ $6,300 Deductible Coverage
❑ $9,450 Deductible Coverage

2) Select a prescription drug coverage option:
❑ Prescription Drug Option A:
$5 generic / $50 brand-name / $90 non-formulary drug copayments AND $2,000 annual maximum benefit.
❑ Prescription Drug Option B:
$5 generic / $50 brand-name / $90 non-formulary drug copayments with NO ANNUAL MAXIMUM BENEFIT.

❑ Medica Encore℠

1) Select your plan's deductible level:
100% Plan
❑ $4,000 Deductible Coverage
❑ $6,500 Deductible Coverage
❑ $9,000 Deductible Coverage

CHA4806-11009

Applicant's Name:_____

C. PAYMENT AND EFFECTIVE DATE SELECTION

1) Initial payment mode *(check one)*
   ❑ Check
   ❑ Credit Card
   Amount paid with this application $ ⌊_|_|_|_|_⌋.⌊_|_|⌋
   (Please make your check payable to Medica. Include the Credit Card Form if applicable.)

2) Ongoing payment mode *(check one)*
   ❑ Check
   ❑ Automatic Payment
   (*Include the ACH Authorization Form if applicable.)*

3) **Effective Date:** Initial payment or payment information for this policy must be submitted with this application. We cannot process your application if you fail to answer all questions completely or if you fail to submit your initial payment. I understand that, if approved by the last day of the month, coverage will be effective the first day of the following month. If possible, I would like my coverage to begin on the first of the month of _____, provided this date is not more than 60 days beyond the signature date of this application.

D. OTHER INSURANCE INFORMATION

1) Do you currently have **any** health insurance coverage? . . . . . ❑ Yes ❑ No
2) Have you ever been a member of Medica? . . . . . ❑ Yes ❑ No
3) Have you had any health insurance coverage within the past 63 days? . . . . . ❑ Yes ❑ No

If "Yes" to any question, you must provide your health coverage history for the past 24 months and complete the insurance information below.

	Insurance company name	Type of coverage	Effective date of coverage	Termination date of coverage
1		❑ Individual coverage ❑ Group coverage ❑ COBRA		
	Reason for termination of health care coverage:			
2		❑ Individual coverage ❑ Group coverage ❑ COBRA		
	Reason for termination of health care coverage:			

4) Will this coverage replace or change any existing health insurance? . . . . . ❑ Yes ❑ No
   If "Yes," please explain why: _____
   _____
   _____
5) Are you covered by Medicare Part A and/or Part B? . . . . . ❑ Yes ❑ No
6) Have you applied for a Medica Individual plan in the past? . . . . . ❑ Yes ❑ No
   If "Yes," when? Month ⌊_|_⌋ Year ⌊_|_|_|_⌋
   Under what primary applicant name? _____

Applicant's Name:_____

E. YOUR HEALTH INFORMATION

Answer every question by checking a Yes or No box. For each question answered "Yes," please complete Section E7.

SECTION E1: Has any person named on this application ever been diagnosed with, treated for, or consulted with a physician or practitioner for:

	Yes	No
a. Heart attack, coronary artery disease, heart bypass surgery, angioplasty, heart valve replacement or congestive heart failure?	❑	❑
b. Stroke, aneurysm, carotid artery blockage, blood clots, embolism or multiple sclerosis?	❑	❑
c. Emphysema, chronic obstructive pulmonary disease (COPD) or pulmonary fibrosis?	❑	❑
d. Hepatitis*, cirrhosis of the liver, pancreatitis, Crohn's disease or ulcerative colitis?	❑	❑
e. Diabetes?	❑	❑
f. Cancer?	❑	❑
g. HIV* positive, AIDS* or lupus?	❑	❑

SECTION E2: Within the past five years, have you been diagnosed with, or treated for, or consulted with a physician or practitioner for:

a. Heart disorders, including but not limited to chest pain, heart murmur, mitral valve prolapse, angina, high blood pressure or cardiovascular disease?	❑	❑
b. Circulatory or vascular disorders, including but not limited to peripheral vascular disease, varicose veins, varicose ulcer, blockage of arteries or other vascular or circulatory disorder?	❑	❑
c. Respiratory disorders, including but not limited to shortness of breath, tuberculosis, asthma, allergies, hay fever, sleep apnea, pneumonia, lung or respiratory disorder?	❑	❑
d. Nervous system disorders, including but not limited to paralysis, epilepsy, fainting, dizziness, seizures, headaches, migraines, or any other disease or disorder of the brain or nervous system?	❑	❑
e. Digestive disorders, including but not limited to stomach or duodenal ulcer, other ulcer, hernia, gastroesophageal reflux disease (GERD), colitis, chronic diarrhea, jaundice, or any disorder of the liver, gallbladder, stomach, intestine, or rectum?	❑	❑
f. Urinary tract disorders, including but not limited to kidney, bladder, kidney and bladder stones, protein or blood in the urine, infection or other disorder(s) of the kidney(s), bladder, ureter(s) urethra, or prostate?	❑	❑
g. Musculoskeletal disorders, including but not limited to arthritis, or any disorder of the joints, muscles or bones, any knee, neck, back or spinal trouble, neuritis, sciatica, spinal curvature to include kyphosis and lordosis, fibromyalgia, gout, carpal tunnel syndrome, TMJ or amputation?	❑	❑
h. Reproductive system disorders, including but not limited to any disease or disorder of the breast or reproductive organs (male and female), complication of breast implants, infertility, abnormal menstrual periods, endometriosis, or sexually transmitted disease?	❑	❑
i. Metabolic or endocrine disorders, including but not limited to sugar intolerance, albumin, blood or sugar in the urine, any disorder of metabolism or endocrine system?	❑	❑
j. Eating disorders, including but not limited to anorexia, bulimia, unexplained weight loss or fever, obesity or other related disorders?	❑	❑
k. Tumor, cysts, neoplasm or growths of any kind?	❑	❑
l. Immune system disorders, including but not limited to collagen disease, scleroderma, rheumatoid arthritis or any other connective tissue disease?	❑	❑
m. Blood disorders, including but not limited to anemia, hemophilia, hemochromatosis, leukemia or any other disease or disorder of the blood?	❑	❑
n. Any disease of the eyes, ears, nose, throat, tonsils, or sinuses?	❑	❑
o. Mental, emotional or nervous disorders, including but not limited to hyperactivity, attention deficit, anxiety, depression or personality disorder?	❑	❑
p. Glandular disorders, including but not limited to Addison disease, Cushing disease, goiter, lymph gland enlargement or any disease or disorder of the adrenal gland, thyroid gland, pituitary, pancreas, or lymph system?	❑	❑
q. Congenital birth or developmental disorders, including but not limited to cleft palate, club foot, congenital heart defects, chromosomal abnormalities, physical or cognitive delays or autism?	❑	❑
r. Skin disorders, acne, psoriasis, warts, lesions or any other disease or disorder of the skin?	❑	❑
s. General fatigue, malaise, mononucleosis, Chronic Fatigue Syndrome or Epstein-Barr Syndrome?	❑	❑

SECTION E3: Within the past five years, have you:

a. Been evaluated for, treated for, or joined any organization for alcoholism/chemical dependency (you are not required to disclose the name of the organization); consumed alcohol to excess or used any controlled drug not prescribed by a doctor or exceeded prescription usage of any drug without physician approval?	❑	❑
b. Been convicted for or had a driver's license suspended for DWI/DUI or been convicted for any alcohol or drug-related moving violation?	❑	❑
c. Been advised by a medical professional to modify or restrict eating or drinking habits for health purposes?	❑	❑
d. Been hospitalized?	❑	❑
e. Been advised by a medical professional to have surgery, treatment or testing, not yet performed?	❑	❑

Continues next page >

* See page 2 for exceptions.

Applicant's Name:_____

E. YOUR HEALTH INFORMATION continued

	Yes	No
f. Participated in organized racing, including but not limited to automobile, motorcycle, or power boat racing or any of the following activities: skydiving, ultralight flying, scuba diving, hang gliding, rodeo participation, rock or mountain climbing?	❑	❑
g. Had an electrocardiogram, MRI, CT scan, echocardiogram, laboratory or diagnostic test or X-ray (other than dental)?	❑	❑
h. Been declined coverage, charged an increased rate, or had benefits excluded from coverage for any health care or life insurance coverage?	❑	❑
i. Had any medical treatment, or diagnosed or treated health impairment not already noted in this enrollment form?	❑	❑

SECTION E4: Are you or have you:

a. Currently pregnant?	❑	❑
b. Considering attempting to get pregnant using assisted reproductive technologies such as infertility drugs or in-vitro fertilization?	❑	❑
c. Had any fixation/prosthetic devices, including but not limited to, plates, screws, pins, implants, shunts, pacemakers, or valve replacement?	❑	❑
d. Currently disabled, hospitalized, on medical leave or receiving disability or workers' compensation benefits?	❑	❑
e. Used tobacco products during the 36 months immediately preceding the date of this application?	❑	❑
f. Within the last six months, been seen by a health professional for any medical treatment?	❑	❑

SECTION E5: Please list the date of last physical exam. Include blood pressure and cholesterol results. If female, please also list date of last Pap smear and result.

		Exam results	Physician name and complete address
1	**Type of exam:**		
	Date of exam:		
2	**Pap smear exam** ***(if female)***		
	Date of exam:		

SECTION E6: Please list all medications taken in the past 12 months. Add an additional page if you need more space.

		Condition treated	Currently taking?
1	**Drug name:**		❑ Yes : Quantity (how many taken each day):
	Dosage: mg/ml		❑ No : Date (mo/yr) stopped:
2	**Drug name:**		❑ Yes : Quantity (how many taken each day):
	Dosage: mg/ml		❑ No : Date (mo/yr) stopped:
3	**Drug name:**		❑ Yes : Quantity (how many taken each day):
	Dosage: mg/ml		❑ No : Date (mo/yr) stopped:

SECTION E7: If you have answered "Yes" to any questions in Sections E1 through E4, please complete this section. Give complete details. Add an additional page if you need more space.

		Diagnosis, treatment and results	Physician name and complete address
1	Question section & letter:		
	Date of onset:		
	Days in hospital:		
	Date of complete recovery:		
2	Question section & letter:		
	Date of onset:		
	Days in hospital:		
	Date of complete recovery:		

Applicant's Name:_____

F. AUTHORIZATION & REPRESENTATION – Read this section, then sign and date the application.

TO BE SIGNED BY APPLICANT:

I have reviewed the above statements/questions and the corresponding answers and represent them to be true and complete. I understand that this application form and any amendments will be the basis for my policy with Medica. Benefits under the policy, if approved, will be based upon the selection made in Section B, unless Medica has offered, and I have accepted, an alternative plan. I understand that if I do not qualify for the coverage selected, Medica may offer an alternative plan. Medica will not rescind coverage that has been in effect for two (2) or more years UNLESS I knowingly made a misstatement on this application form.

I understand and agree that my policy, if approved, will be issued solely as an individual policy. The policy is not offered pursuant to and does not comply with state or federal group health plan laws. I understand and agree that any attempt to use the individual policy in a manner that results in it being considered a group health plan under state or federal law is strictly prohibited.

If there is a change in my health condition between the date of this application and my effective date of coverage, I agree to notify Medica immediately. This new information may be used in determination and/or reversal of my acceptance. If I do not notify Medica of any change in my health condition prior to my effective date of coverage, my policy may be rescinded.

On behalf of myself, I authorize any hospital, clinic, institution, physician, insurance company, MIB, Inc. ("MIB"), or other organization, institution or person to give Medica or any of its designees any and all records or information pertaining to medical history or services rendered to me including, but not limited to, information relating to any medical records or medical insurance claims, consultations or treatments; outpatient or inpatient hospital services; prescription information and lab work. 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 information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality, and that I have the right to see and correct my 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. 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 blood borne pathogen as described on page 2 of this enrollment form. I also authorize the use of a Social Security Number for the purpose 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 me on this application may invalidate my 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 eligibility and enrollment for benefits. Unless revoked, this authorization will remain in effect until termination of coverage. Information used or disclosed pursuant to this authorization will remain subject to Medica's privacy standards. A photographic copy of this authorization shall be as valid as the original. I understand if I am approved for coverage, my policy will not cover preexisting conditions during the first 18 months following my enrollment date. However, if I have maintained continuous health care coverage, the preexisting condition limitation applies during the first 12 months following the enrollment, and will be reduced by the aggregate of certain periods of qualifying coverage applicable to me as of the enrollment date. I authorize Medica to disclose my protected health information to the Guarantor identified below if I am under age 18 and if such information is the basis for Medica's denial of coverage.

I know that my application contains personal information, including my health care information. By checking "Yes" in the space provided, I will be releasing my application to both Medica and my broker of record, who will have access to my personal information. By checking "No" in the space provided, I will be releasing my application only to Medica. My broker of record will not receive my application or have access to my personal information. My choice will not affect my eligibility for the policy I am applying for . . . . . ❑ Yes ❑ No

X _____ _____

Signature of Applicant — Date

X _____ _____

Signature of Guarantor, Parent or Legal Guardian (Please complete if the Applicant is under age 18) — Date

A person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

G. FOR AGENT USE ONLY

Application was completed by ❑ **Applicant (Parent or Legal Guardian if applicant is under age 18)** ❑ **Agent**. 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. ***Please write legibly for this to be processed.***

X		Jamie Williams - #98173	(612) 870-8099
Signature of Agent	Date	Print Agent's Name & Number	Agent's Telephone Number

H. FOR OFFICE USE ONLY

Date Received	Policy Effective Date	Plan Code	PE Mo.	Reviewed By: Date: A D	Payment ID	Amount

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 CP320
PO Box 9310, Minneapolis, MN 55440-9310

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