

MEDICA®

MINNESOTA

**Medica Direct
HSASM for Individuals**

**Medica Direct
ValueSM for Individuals**

Application Form

IMPORTANT INFORMATION ABOUT YOUR APPLICATION

- Please review your application to assure that every question has been completed and thoroughly answered.
- Questions in Section F pertain to all persons named on this application. To avoid unnecessary delays, please provide a complete explanation of all “yes” answers in the space provided under Section F7. 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.
- Note that any person named on this application who is pregnant or an expectant parent (including adoption) is not eligible for coverage.
- See Section D3, 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 credit card information 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. All adults, including dependent children age 18 and over, must sign. 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 plan and deductible you are applying for in Section C.
- 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.

C. BENEFIT SELECTION (select either HSA or Value and fill out appropriate section)

MEDICA DIRECT HSA FOR INDIVIDUALS

1) Select your choice of the following coinsurance plan and calendar year deductible.

80% Plan

- \$1,450 Individual Coverage/\$2,900 Family (2 or more) Coverage
- \$1,850 Individual Coverage/\$3,750 Family (2 or more) Coverage
- \$4,500 Individual Coverage/\$8,000 Family (2 or more) Coverage

100% Plan

- \$1,850 Individual Coverage/\$3,750 Family (2 or more) Coverage
- \$2,500 Individual Coverage/\$4,650 Family (2 or more) Coverage
- \$2,950 Individual Coverage/\$5,650 Family (2 or more) Coverage
- \$3,600 Individual Coverage/\$7,250 Family (2 or more) Coverage
- \$5,800 Individual Coverage/\$9,300 Family (2 or more) Coverage

2) **First Dollar Preventive Election** – I want to **include**, at an additional cost, First Dollar Preventive Care Coverage. The coverage includes the following preventive services: routine physicals, routine eye exams, health education services and cancer screenings. I understand that the deductible, and if applicable, coinsurance does not apply for the first \$300 in benefits paid on a calendar year basis for each covered person. I understand this election applies to all persons for whom application is being made. I also understand that this election will be in force for the duration of my policy. Note: If you do not choose this election, preventive care (except for prenatal and well child services) is subject to deductible before benefits are paid. Yes No

3) **Mental Health Coverage Election** – I want to **include**, at an additional cost, benefits for consultation, diagnosis and treatment of mental disorders including inpatient and outpatient services. I understand this election applies to all persons for whom application is being made. I also understand that this election may be made **only** at the time of this initial application. This election will be in force for the duration of my policy. Yes No

MEDICA DIRECT VALUE FOR INDIVIDUALS

1) Select your choice of the following policy year deductible. \$150 \$500 \$1,000 \$1,500 \$2,500 \$5,000

2) **Mental Health Coverage Election** – (Applies to plans with a deductible of \$1,000 or more. Mental Health coverage will be automatically included in Medica Direct Value for Individuals plans with a deductible of less than \$1,000). I want to **include**, at an additional cost, benefits for consultation, diagnosis and treatment of mental disorders including inpatient and outpatient services. I understand this election applies to all persons for whom application is being made. I also understand that this election may be made **only** at the time of this initial application. This election will be in force for the duration of my policy. Yes No

3) **Chemical Dependency Coverage** – Chemical Dependency coverage is part of the benefit package and includes treatment or consultation for alcoholism, chemical dependency or drug addiction. I want to **decline** coverage for these benefits, which will result in a premium reduction. I understand that this applies to all persons for whom application is being made and may be made **only** at the time of initial application. Yes No

F. HEALTH INFORMATION

Answer every question by checking a Yes or No box. Circle the medical condition(s) listed and complete Section F7 for all questions answered "Yes" for you and each person applying for coverage.

Section F1: 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Stroke, aneurysm, carotid artery blockage, blood clots, embolism or multiple sclerosis? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Emphysema, chronic obstructive pulmonary disease (COPD) or pulmonary fibrosis? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Hepatitis*, cirrhosis of the liver, pancreatitis, Crohn's disease or ulcerative colitis? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Diabetes? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Cancer? | <input type="checkbox"/> | <input type="checkbox"/> |
| g. HIV* positive, AIDS* or lupus? | <input type="checkbox"/> | <input type="checkbox"/> |

Section F2: Within the past five years, has any person named on this application been diagnosed with, treated for, or consulted with a physician or practitioner for:

- | | Yes | No |
|---|--------------------------|--------------------------|
| a. Heart disorders, including but not limited to chest pain, heart murmur, mitral valve prolapse, angina, high blood pressure or cardiovascular disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Respiratory disorders, including but not limited to shortness of breath, tuberculosis, asthma, allergies, hay fever, sleep apnea, pneumonia, or other lung disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Eating disorders, including but not limited to anorexia, bulimia, unexplained weight loss or fever, obesity or other related disorders? | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Tumor, cysts, neoplasm or growths of any kind? | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Immune system disorders, including but not limited to collagen disease, scleroderma, rheumatoid arthritis or any other connective tissue disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| m. Blood disorders, including but not limited to anemia, hemophilia, hemochromatosis, leukemia or any other disease or disorder of the blood? | <input type="checkbox"/> | <input type="checkbox"/> |
| n. Any disease of the eyes, ears, nose, throat, tonsils, or sinuses? | <input type="checkbox"/> | <input type="checkbox"/> |
| o. Mental, emotional or nervous disorders, including but not limited to hyperactivity, attention deficit, anxiety, depression or personality disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| r. Skin disorders, acne, psoriasis, warts, lesions or any other disease or disorder of the skin? | <input type="checkbox"/> | <input type="checkbox"/> |
| s. General fatigue, malaise, mononucleosis, Chronic Fatigue Syndrome or Epstein-Barr Syndrome? | <input type="checkbox"/> | <input type="checkbox"/> |

* See page 2 for exceptions.

F. HEALTH INFORMATION (continued)

Answer every question by checking a Yes or No box. Circle the medical condition(s) listed and complete Section F7 for all questions answered "Yes" for you and each person applying for coverage.

Section F3: Within the past five years, has any person named on this application: **Yes No**

a. Been evaluated for or treated for alcoholism/chemical dependency; 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 to have surgery, treatment or testing, not yet performed?

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 application?

Section F4: Is any person or has any person named on this application: **Yes No**

a. An expectant father or expectant mother or anticipating the adoption of a child?

b. Expecting to become a parent through the use of assisted reproductive technologies such as infertility drugs or in-vitro fertilization?.

c. Had any fixation/prosthetic device, 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 F5: Please list the date of last physical exam for all persons named on this application. Include blood pressure and cholesterol results, and all results of physical exam and diagnostic tests.

Person's name	Name and address of physician	
Date of exam	Type of exam	Results
Person's name	Name and address of physician	
Date of exam	Type of exam	Results
Person's name	Name and address of physician	
Date of exam	Type of exam	Results
Person's name	Name and address of physician	
Date of exam	Type of exam	Results
Person's name	Name and address of physician	
Date of exam	Type of exam	Results

Applicant's Name: _____

F. HEALTH INFORMATION (continued)

Section F6: Please list all medications taken for any persons named on this application in the past 12 months. Add additional page if you need more space.

Person's name	Drug name	mg/ml
Condition	Currently taking? <input type="checkbox"/> Yes : Dosage (how many taken each day): <input type="checkbox"/> No : Date (month/year) stopped:	
Person's name	Drug name	mg/ml
Condition	Currently taking? <input type="checkbox"/> Yes : Dosage (how many taken each day): <input type="checkbox"/> No : Date (month/year) stopped:	
Person's name	Drug name	mg/ml
Condition	Currently taking? <input type="checkbox"/> Yes : Dosage (how many taken each day): <input type="checkbox"/> No : Date (month/year) stopped:	
Person's name	Drug name	mg/ml
Condition	Currently taking? <input type="checkbox"/> Yes : Dosage (how many taken each day): <input type="checkbox"/> No : Date (month/year) stopped:	
Person's name	Drug name	mg/ml
Condition	Currently taking? <input type="checkbox"/> Yes : Dosage (how many taken each day): <input type="checkbox"/> No : Date (month/year) stopped:	
Person's name	Drug name	mg/ml
Condition	Currently taking? <input type="checkbox"/> Yes : Dosage (how many taken each day): <input type="checkbox"/> No : Date (month/year) stopped:	
Person's name	Drug name	mg/ml
Condition	Currently taking? <input type="checkbox"/> Yes : Dosage (how many taken each day): <input type="checkbox"/> No : Date (month/year) stopped:	
Person's name	Drug name	mg/ml
Condition	Currently taking? <input type="checkbox"/> Yes : Dosage (how many taken each day): <input type="checkbox"/> No : Date (month/year) stopped:	
Person's name	Drug name	mg/ml
Condition	Currently taking? <input type="checkbox"/> Yes : Dosage (how many taken each day): <input type="checkbox"/> No : Date (month/year) stopped:	

Applicant's Name: _____

F. HEALTH INFORMATION (continued)

Section F7: If you have answered "Yes" to any questions in Sections F1 through F4, please complete this section. Give complete details. Add an additional page if you need more space.

Person's name		Diagnosis, treatment and results
Question No.	Days in hospital	
Date of onset	Date of complete recovery	Name and address of physician

Person's name		Diagnosis, treatment and results
Question No.	Days in hospital	
Date of onset	Date of complete recovery	Name and address of physician

Person's name		Diagnosis, treatment and results
Question No.	Days in hospital	
Date of onset	Date of complete recovery	Name and address of physician

Person's name		Diagnosis, treatment and results
Question No.	Days in hospital	
Date of onset	Date of complete recovery	Name and address of physician

Person's name		Diagnosis, treatment and results
Question No.	Days in hospital	
Date of onset	Date of complete recovery	Name and address of physician

Person's name		Diagnosis, treatment and results
Question No.	Days in hospital	
Date of onset	Date of complete recovery	Name and address of physician

Person's name		Diagnosis, treatment and results
Question No.	Days in hospital	
Date of onset	Date of complete recovery	Name and address of physician

Person's name		Diagnosis, treatment and results
Question No.	Days in hospital	
Date of onset	Date of complete recovery	Name and address of physician

Person's name		Diagnosis, treatment and results
Question No.	Days in hospital	
Date of onset	Date of complete recovery	Name and address of physician

Applicant's Name: _____

G. AUTHORIZATION & REPRESENTATION – Read this section, date and sign 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 C, unless Medica has offered, and I have accepted, an alternative plan. I understand that if I, or any person named on this application do(es) not qualify for the coverage selected, Medica may offer alternative plans to some or all of us. If there is a misstatement in this application, Medica will not use a misstatement to rescind coverage that has been in effect for two (2) years starting from the effective date of coverage. This time limit does not apply to misstatements that are knowingly made on this application.

I understand and agree that my policy, if approved, will be issued solely as an individual/family policy and is offered pursuant to and in compliance with state and federal individual health plan laws. 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 (or my spouse's or dependent's) 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 (or my spouse's or dependent's) health condition prior to my effective date of coverage, my policy may be rescinded.

On behalf of myself and anyone enrolled on or added to this application ("Us"), 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 Us 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 the individuals enrolled on or added to this application have the right to see and correct their 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 for persons as described on page 2 of this enrollment form. I also authorize on behalf of Us 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 Us on this application may invalidate my or my dependent's 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 and my dependent's 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.

As a spouse or dependent named on this application, I authorize Medica to disclose my protected health information to the Applicant if such information is the basis for Medica's denial of coverage.

I know that my application contains personal information, including health care information, about me (and my dependents). 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 Spouse or Other Insured
(If proposed to be insured)

Date

X

Signature(s) of Other Dependents 18 or Over
(If proposed to be insured) 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.

Applicant's Name: _____

H. FOR AGENT USE ONLY

Application was completed by

- applicant**
 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.

Agent's Signature X		Date
Print Agent's Name	Agent's Number	Agent's Telephone Number ()

Please write legibly for this to be processed.

I. FOR OFFICE USE ONLY

Date Received	Eff. Date of Policy	Plan Code	PE Mo. A. B. C. D. E.					
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®

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