MEDICA®

Enrollment Application for Medica Advantage Solution℠ Standard

Medica Advantage Solution is a Medicare Advantage Private-Fee-for-Service product offered by Medica Health Plans and Medica Insurance Company, organizations with Medicare contracts with the Centers for Medicare and Medicaid Services (CMS). Medica Advantage Solution is a member of the Medica Medicare Solutions® family of products and services.

A Medicare Advantage Private-Fee-for-Service plan works differently than a Medicare supplement plan. Your doctor or hospital is not required to agree to accept the plan's terms and conditions, and thus may choose not to treat you, with the exception of emergencies. If your doctor or hospital does not agree to accept our payment terms and conditions, they may choose not to provide healthcare services to you, except in emergencies. Providers can find the plan's terms and conditions on our Web site at www.medica.com.

Important Information

1. Review the enclosed Summaries of Benefits for enrollment requirements and details on the plans available. Then, make your plan selection by checking the appropriate box on page 2 of this application form.
2. Complete all sections of the application in full. Please make sure you have completed and forwarded all necessary information to Medica. Missing or incomplete information may cause a delay in effective date of your coverage. Use a black or blue pen and print firmly.
3. If you have any questions concerning your application, please contact Customer Service 8 a.m. to 8 p.m. CST, seven days a week at 952-992-2345 or 1-800-906-5432. TTY users may call 952-992-3650 or 1-800-234-8819.
4. You must have Medicare Part A and Part B to join a Medicare Advantage plan. You must continue to pay your Medicare Part B premium.
5. You may enroll in a Medicare Advantage plan during the annual enrollment period between November 15 and December 31 of each year. In addition, you can join a Medicare Advantage plan during the open enrollment period between January 1 and March 31 of each year, as long as you do not add or drop your prescription drug coverage. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of these periods. Please complete the Medica Advantage Solution Enrollment Checklist and submit it with this application. You may contact our Customer Service department if you would like assistance.
6. **If you currently have health coverage from an employer or union, joining Medica Advantage Solution with prescription coverage may affect your employer or union health benefits and may change how your current coverage works.** Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Medica Advantage Solution℠ Standard Enrollment Application

Section One: Complete this section about yourself
(Please print your name exactly the way it appears on your Medicare card)

Legal First Name	M.I.	Last Name	Sex ❑ Male ❑ Female

Permanent Residence Address	City	State	Zip	County
Mailing Address (if different from above)	City	State	Zip	County

Home Phone (with area code)	Social Security Number (optional)	Birth Date (__ __ / __ __ / __ __ __ __) (M M / D D / Y Y Y Y)	What is your Preferred Language?

I am applying for (check option):

Medica Advantage Solution:
❑ MN/ND Standard $0/month
❑ MN/ND Standard with Rx $23.90/month
❑ WI Standard $0/month
❑ WI Standard with Rx $23.90/month

You must continue to pay your Medicare Part B premium.

Section Two: Medicare information (Your enrollment form cannot be processed without this information.)

We must verify your Medicare eligibility.
Please select one of the following options:

- Fill in these blanks to the right so they **MATCH** what appears on your red, white and blue Medicare card; ***OR***
- Attach a copy of your Medicare card; ***OR***
- Attach a copy of your Letter of Verification for Medicare eligibility from the Social Security Administration or Railroad Retirement Board.

MEDICARE HEALTH INSURANCE

SAMPLE ONLY

Name:___________________________________

Medicare Claim Number: Sex:

_ _ _ - _ _ - _ _ _ _ - _ ______

Is Entitled To Effective Date

___Hospital Insurance (Part A): ________________

___Medical Insurance (Part B): ________________

Section Three: Payment method (Please do not submit payment with application)

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium for this benefit. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare does not cover.

Please choose a payment method:

❑ **Monthly Invoicing**
❑ **Monthly ACH** – automatic deduction from your checking or savings account (paperwork completed and attached).
❑ **Social Security** – automatic deduction from your check. (This option is only available if you have selected a plan with prescription drug coverage. The deduction may take two or more months to begin. In most cases, the first deduction will include all premiums due from your enrollment effective date up to the point withholding begins. Generally you must stay with this option for the rest of the year.)

Section Four: Please answer these questions. (This information is NOT used for health screening)

1. Do you have End-Stage Renal Disease (ESRD)? . . . . ❑ **YES** ❑ **NO**
   You can not enroll in this plan if you have ESRD, unless: (A) you are already enrolled in a Medica plan as a non-Medicare member and you developed ESRD while a Medica member; or (B) you have had a successful kidney transplant and no longer require dialysis (please attach a note or records from your doctor showing you no longer need dialysis or have had a successful kidney transplant).

Section Four: Please answer these questions. (continued)

2. On the effective date you are requesting, will you have another Medicare policy or certificate in force (including a Medicare supplement, Cost Plan or a Medicare Advantage policy) . . . . ❑ YES ❑ NO

   If YES, please list name of the plan ____

   If YES, you may need to send written cancellation of your membership to your current plan. You should not cancel your current plan until you have received confirmation of the effective date of your Medica Advantage Solution Plan.

3. Do you have health coverage through your or your spouse's current or former employer? . . . . ❑ YES ❑ NO

   If YES, please provide the following information:
   Employer Name__________________________ Employer Address ______________________
   Policyholder Name______________________________ Policy Number __________________

4. Only answer this question if you have selected a Medica Advantage Solution Plan with prescription drug coverage. Some individuals may have other (non Part D) drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA Benefits or State Pharmaceutical Assistance Programs. Do you or will you have other (non Part D) prescription drug coverage in addition to this Medica Advantage Solution Plan with Part D? . . . . ❑ YES ❑ NO

   If YES, please list your other coverage and your identification (ID) number(s):

   Name of other coverage: ID # for coverage: Group # for coverage:

   ____________________________________ ____________________ ____________________

5. Are you a resident in a long-term care facility, such as a nursing home? . . . . ❑ YES ❑ NO

   If YES, please provide the following information:
   Name of institution:____
   Address and telephone number of institution (number and street): ________________________

   ____

6. Are you enrolled in your State Medicaid program? . . . . ❑ YES ❑ NO

   If YES, please provide your Medicaid number: ____

Section Five: Statements of understanding

I hereby authorize the Centers for Medicare and Medicaid Services (CMS) to furnish information to Medica affirming my entitlement to Hospital Insurance Benefits (Part A) and enrollment for Supplementary Medical Insurance Benefits (Part B) under Title XVIII of the Social Security Act. I authorize Medica or any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services or intermediaries or carriers any information needed to administer Title XVIII of the Social Security Act.

I understand that Medica Advantage Solution is a Medicare Advantage plan and I will need to keep my Medicare Parts A and B. I can only be in one Medicare Advantage plan at a time and I can only be in one Medicare prescription drug plan at a time. It is my responsibility to inform Medica of any other prescription drug coverage that I have or may get in the future. I understand that if I do not have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year. **I may leave this plan only at certain times of the year**, or under certain special circumstances, by calling or sending a request to Medica or by calling 1-800-Medicare, 24 hours per day, 7 days per week. TTY users should call 1-877-486-2048.

I understand that, beginning with my effective date, I must use health care providers that agree to accept the plan's terms and conditions. Medica Advantage Solution serves a specific service area. If I move out of the area that Medica Advantage Solution serves, I need to notify Medica so I can disenroll and find a new plan in my new area. Once I am a member of Medica Advantage Solution, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Medica when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan. I understand that Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage near the U.S. border. Services contained in my Medica Evidence of Coverage document will be covered.

Section Five: Statements of understanding (continued)

I understand the person that is discussing plan options with me is either employed by or contracted with Medica. The person may be compensated based on my enrollment in a plan.

I authorize Medica to release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also authorize Medica to release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations.

I authorize the U.S. Department of Health and Human Services (or its designees) and any health care professional or entity, insurance company, or other person to give Medica or any of its designees any and all records or information pertaining to medical history or services rendered to me. I understand that this information will be used for enrollment or eligibility for benefits. I understand that in certain circumstances Medica may disclose the information collected to third parties without authorization and that I have the right to see and correct my personal information in accordance with applicable law. I understand that Medica may disclose information to my agent of record for the purpose of assisting me with the administration of my account. I understand that I have the right to request restrictions on the use or disclosure of protected health information. Medica is not required to agree to any such restrictions, but it if does agree, Medica will abide by the terms of the restrictions. Any protected health information obtained under this authorization shall remain subject to Medica's privacy standards. I understand that I have the right to review the Privacy Notice before signing this form and to request a copy at any time. I also authorize the use of Social Security Number (if provided) or a Medicare Claim Number for the purpose of identification. I have the right to revoke this authorization at any time by providing written notice to Medica. I understand that Medica conditions enrollment on this authorization and my revocation or failure to provide authorization may affect my enrollment. If I revoke the authorization, it will not affect any actions already taken by Medica prior to Medica's receipt of the revocation. Unless revoked, this authorization remains in effect until termination of coverage. 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.

APPLICANT

I am requesting an effective date of ________________. I understand my effective date is assigned by Medica and I will receive written notification.

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by Medica or by Medicare.

X ____ / /

Your Signature — Today's Date

If you are the authorized representative, you must provide the following information:

Name:______________________________ Address:______________________________

Phone Number: (____) ______ – _________ Relationship to Enrollee: ______________________________

AGENT

X ____ / /

Agent Signature — Agent Name and ID # (Please Print) — Agent Phone # — Date

Please write legibly to ensure correct processing.

MEDICA USE

Election Period:

❑ AEP ❑ OEP ❑ SEP ❑ ICEP

Proposed Eff. Date: ______________________

Group #: ______________ Cycle #: _______

County Code: ___________

Initial Receipt Date	Control Receipt	Deemed Complete	Data Entry Date

MEDICA®

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