MEDICA®

Medica Individual and Family Plans

NORTH DAKOTA CHANGE FORM

This form may be used to complete the following changes to your Medica plan:

- Name or address change
- Newborn or adoption addition
- Member termination
- Move to a higher deductible
- Change office visit copayment
- Remove mental health/substance abuse coverage
- Reduce prescription drug coverage to include only generic drugs

Thank you for being a Medica member!

SECTION A MEMBER INFORMATION

Note: This section must be completed.

Subscriber

Last name:	First name:	M.I.:	Social Security Number:

Current member I.D. number:	Preferred telephone number:	Alternate telephone number:

SECTION B ADDRESS CHANGE (if applicable)

Change address from		**Change address to**	
Street:		Street:	
City:		City:	
State:	Zip Code:	State:	Zip Code:

SECTION C NAME CHANGE (if applicable)

Change name from			**Change name to**		
Last name:	First name:	M.I.	Last name:	First name:	M.I.

SECTION D ADDITIONS OR TERMINATIONS (if applicable)

Note: Member additions are only available for Medica Encore,℠ Medica Symphony,® and Medica Direct HSA℠ plans.

Addition of dependent child

❑ Newborn *(Enter date of birth as the effective date below)*
❑ Adoption *(Enter date of placement as the effective date below)*

Effective date *(MM/DD/YY)* of addition: / /

Note: Spouses or other types of dependents can only be added by completing an Application Form which is subject to underwriting.

Termination of coverage

❑ Dependent ineligible ❑ Death
❑ Other:

Effective date *(MM/DD/YY)* of termination: / /

Note: Coverage may end on the last day of any month. The effective date must be within 60 days of this Change Form's signature date.

Type of change	Last name	First name	M.I.	Social Security Number	Relationship to applicant	Sex	Birth date *(MM/DD/YY)*
❑ Addition ❑ Termination						M F	
❑ Addition ❑ Termination						M F	
❑ Addition ❑ Termination						M F	

ND-SESH-CF-11-01

Subscriber's Name:

MEDICA®

Valid: January 2011 through December 2011

SECTION E

PLAN AND BENEFITS CHANGE (if applicable)

Note: Reductions in maximum out-of-pocket amounts or adding coverage options **cannot** be made without completing a new Application Form which is subject to underwriting. If you make a plan change, annual benefit limits including deductible, out-of-pocket amounts and any other benefit limits may start over.

To learn more about your plan coverage options, please contact your broker or a Medica representative at 952-992-1805 or 866-894-8051 for assistance.

	Medica Solo ❑	Medica Encore ❑	Medica Symphony ❑	Medica Direct HSA ❑
1.	**Choose your plan's new coverage level and increased deductible amount**			
	❑ **No change to deductible** ❑ **Change deductible:** 80% one-person coverage ❑ $3,000 ❑ $6,000 ❑ $9,000 ❑ $12,000	❑ **No change to deductible** ❑ **Change deductible:** 100% one-person coverage ❑ $4,000 ❑ $6,500 ❑ $9,000 100% two-person coverage ❑ $6,000 ❑ $7,500 ❑ $9,000	❑ **No change to deductible** ❑ **Change deductible:** 70% one-person coverage ❑ $3,000 ❑ $6,000 ❑ $9,000 70% individual+one coverage ❑ $6,000 ❑ $12,000 ❑ $18,000 70% family coverage ❑ $9,000 ❑ $18,000 ❑ $27,000	❑ **No change to deductible** ❑ **Change deductible:** 80% one-person coverage ❑ $2,000 ❑ $3,000 ❑ $4,000 80% family coverage ❑ $3,500 ❑ $5,000 ❑ $6,500 100% one-person coverage ❑ $2,000 ❑ $3,000 ❑ $4,000 100% family coverage ❑ $3,500 ❑ $5,000 ❑ $6,500
2.	**Choose your plan's new office visit copayment amount**			
	Your copayment is tied to your deductible level	❑ **No change to copayment** ❑ **Change copayment:** ❑ Option A: $20 copay ❑ Option B: $40 copay ❑ Option C: $60 copay	❑ **No change to copayment** ❑ **Change copayment:** ❑ Option A: $30 copay ❑ Option B: $60 copay	***Not applicable***
3.	**Mental health and substance abuse coverage option:** If you currently have mental health/substance abuse coverage in your plan, you can choose to continue or remove this coverage.			
	❑ **Continue coverage** ❑ **Remove coverage**	❑ **Continue coverage** ❑ **Remove coverage**	❑ **Continue coverage** ❑ **Remove coverage**	***Not applicable***
4.	**Prescription drug coverage option:** If you currently have coverage for brand-name drugs in your plan, you can choose to continue coverage for brand-name drugs or reduce coverage to generic drugs only.			
	❑ **Continue coverage for brand-name drugs** ❑ **Reduce coverage to generic drugs only**	❑ **Continue coverage for brand-name drugs** ❑ **Reduce coverage to generic drugs only**	❑ **Continue coverage for brand-name drugs** ❑ **Reduce coverage to generic drugs only**	***Not applicable***
5.	**Requested effective date of policy change(s)**			

Note: Policy changes must start on the 1st of any month. Policy changes can begin the day after this form is received by Medica. The effective date must be within 60 days of the signature date.

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

SECTION

F AUTHORIZATION AND REPRESENTATION

TO BE SIGNED BY SUBSCRIBER

I understand and agree this change form will not alter any other limitations, conditions, provisions or exclusions that were part of my policy or application prior to the effective date of this plan change. I understand that I will not be allowed to return to a lower deductible amount without providing a health history and application.

I understand that my premium may be impacted by the change(s) requested on this form. I will be responsible for any additional premium amount due from the effective date of the change(s). I understand that any reduction in premium will be reflected on the billing invoice.

The information provided on this form is accurate and complete. I understand and agree that any omissions or incorrect statements intentionally made by me on this form may invalidate my coverage.

By signing below, I agree that this change form amends the original and will be incorporated into and made part of the application form and the policy.

Signature of Subscriber: Date:

X

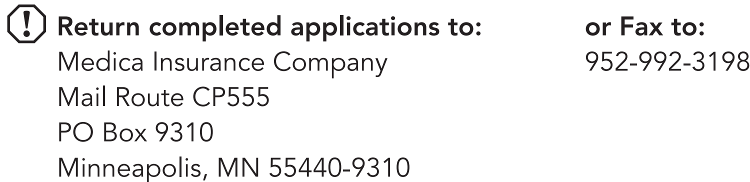
I authorize Medica to make the changes to my policy as requested by the Subscriber and identified on this change form.

Signature of Other Members Over Age 18: Date: X	Signature of Other Members Over Age 18: Date: X

Please provide signature below if the Primary Applicant is under age 18:

Signature of Guarantor, Parent or Legal Guardian: Date:

X



Return completed applications to:
Medica Insurance Company
Mail Route CP555
PO Box 9310
Minneapolis, MN 55440-9310

or Fax to:
952-992-3198

FOR OFFICE USE ONLY

Effective date of change:	Reviewed by: Date:	New plan code:	PE Mos.: | |	Premium change: ❑ Y ❑ N	Rollover: ❑ Y ❑ N

Mail Route CP555, PO Box 9310, Minneapolis, MN 55440-9310

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