

Primary Applicant's Name:

NORTH DAKOTA APPLICATION FORM

General Medica policy information

- This application, if approved, will issue an individual/family policy only. The policy is not offered as a group health plan and Medica strictly prohibits it to be used as such.
- Your Social Security Number will be used for the purpose of identification only.
- Any person named on this application who is pregnant is not eligible for a Medica SoloSM, Medica EncoreSM, Medica Symphony[®], Medica Symphony[®] for HSA, Medica Direct Basic, or Medica Direct Standard plan.
- Any person named on this application who is an expectant parent (including adoption) is not eligible for a Medica EncoreSM, Medica Symphony[®], Medica Symphony[®] for HSA, Medica Direct Basic, or Medica Direct Standard plan.
- Online applications are available at **medica.com**. Applying online may reduce your application's processing time.

Completing your application

- Complete all sections within the application thoroughly and accurately. Applications with missing or inaccurate information will be delayed in processing and may result in rescission of your policy.
- Questions in Section F pertain to all persons listed in this application. All questions answered "Yes" in Sections F2 through F4 require a complete explanation in Section F5.

Submitting your application

- 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. All adults, including dependent children age 18 and over, must sign. Primary applicants must be 19 years of age or older.
- Your application 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 if you wish to be considered for coverage.
- See Section G for information on your effective date. Medica will notify you if you (or anyone listed in this application) have been approved and the effective date of coverage. The processing time for your application is approximately two to four weeks. **Do not cancel any existing coverage until the Medica policy has been approved, issued and accepted by you.**
- Make a copy of your completed application for your personal records. If you are approved for coverage, this copy will become a part of your contract.

⚠ Contact us if you have questions

Please contact a Medica Sales Service Specialist 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.

Primary Applicant's Name:

SECTION

B APPLICANT INFORMATION

Primary Applicant

| | | | | | |
|---|--|--|--|---|-----------------|
| Last name: | | First name: | | | Middle initial: |
| Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married | Preferred telephone number: + | Alternate telephone number: + | | Best time to call: <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon | |

Email address *(by providing you agree that Medica may send you e-mails):*

Applicant's home address

| | | | |
|---------|-------|--------|-----------|
| Street: | City: | State: | Zip Code: |
|---------|-------|--------|-----------|

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

| | | | |
|---------|-------|--------|-----------|
| Street: | City: | State: | Zip Code: |
|---------|-------|--------|-----------|

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

Premium payments

Will any portion of the premium be paid by the employer or anyone listed in this application, either directly or through wage adjustments or other means of reimbursement? Yes No

Will you pay any portion of health insurance premiums using pretax dollars or will an employer for anyone listed on this application pay a portion of your health insurance premiums or provide reimbursement for uninsured medical expenses for anyone listed on this application? *(Section 162, Section 125 or Section 106 of the U.S. Internal Revenue Code)*. . . . Yes No

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

! **Note:** Medica Solo is a one-person maximum policy. Medica Encore is a two-person maximum policy. Medica Symphony, Medica Symphony for HSA, Medica Direct Standard and Medica Direct Basic are family policies. Your application will not be processed if you exceed the maximum number of persons allowed on your selected plan.

| First name | Middle initial | Last name | Social Security No. | Sex | Relationship to applicant | Birth date <i>mo/day/yr</i> | Height | Present weight | Weight one year ago |
|------------|----------------|-----------|---------------------|--------|---------------------------|-----------------------------|---------|----------------|---------------------|
| | | | | M F | (primary applicant) | | ft. in. | lbs. | lbs. |
| | | | | M F | | | ft. in. | lbs. | lbs. |
| | | | | M F | | | ft. in. | lbs. | lbs. |
| | | | | M F | | | ft. in. | lbs. | lbs. |
| | | | | M F | | | ft. in. | lbs. | lbs. |
| | | | | M F | | | ft. in. | lbs. | lbs. |

Primary Applicant's Name:

SECTION C PLAN AND BENEFITS SELECTION

Note: Medica cannot process your application if your Plan and Benefits Selection page is not completed. This page can be found as the last page of your application. You may also find it online at medica.com. If you are adding a dependent to your current plan, 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.

Initial payment (first payment must be submitted with this application)

Choose payment method:

Check (make payable to Medica) Credit Card (submit with the Credit Card Form)

Amount paid with this application:

\$

Ongoing payments

Choose payment method:

Check ACH Automatic Payment from your checking account (complete the ACH Authorization Form)

SECTION E OTHER INSURANCE INFORMATION

Note: Incomplete information in this section may result in a pre-existing condition limitation applied to claims for individuals age 19 and older, and a resulting delay in claims payment could occur.

- 1. Would this coverage replace or change any existing health insurance?
2. Is any person named on the application covered by Medicare?
3. Do you currently have any health insurance or have you had any health insurance within the past 63 days?

If Yes, you must provide your health coverage history for the past 12 months by completing the insurance information below:

Table with 5 columns: Coverage start date, Coverage end date, List all persons covered under policy, Name of insurance company, Type of insurance. Includes checkboxes for Individual, Group, and COBRA.

SECTION F HEALTH INFORMATION

Note: Any change in applicant's or dependent's health history that occurs between your signature date on this application and the effective date of coverage must be reported to Medica immediately. This includes doctor visits, diagnosed conditions or diseases, or any other medical related issues.

F1 SECTION F1: Is any person or has any person named on this application:

- A. Had a positive pregnancy test in the last 90 days, or are currently an expectant parent (male or female), regardless of whether or not the mother is listed on the application?
B. Used tobacco products within the last 12 months?
C. Currently disabled, hospitalized, on medical leave or receiving disability or workers' compensations benefits?

F HEALTH INFORMATION (continued)

! **Note:** Answer every question in Sections F2 through F4 by checking a "Yes" or "No" box or by checking the health conditions that apply. Complete Section F5 for all conditions checked or all questions answered "Yes" for you and each person applying for coverage.

F2 SECTION F2: Has any person named on this application ever been diagnosed with, treated for, or consulted with a physician or practitioner for:

- A. Heart attack, coronary artery disease, heart bypass surgery, angioplasty, heart valve replacement, congestive heart failure or cardiomyopathy? Yes No
- B. Aneurysm, Muscular Dystrophy, ALS or Multiple Sclerosis? Yes No
- C. Emphysema, chronic obstructive pulmonary disease (COPD) or pulmonary or cystic fibrosis? Yes No
- D. Hepatitis C, cirrhosis of the liver or Crohn's disease? Yes No
- E. Diabetes Type II? Yes No
- F. Leukemia, Hodgkin's Disease, lymphoma or other type of cancer; including but not limited to breast, colon, kidney, lung or prostate? Yes No
- G. HIV Positive or AIDS? Yes No
- H. Scleroderma, systemic lupus or Diabetes Type I? Yes No
- I. Organ transplant (other than cornea)? Yes No

F3 SECTION F3: Within the past 5 years, has any person named on this application been diagnosed with, treated for, or consulted with a physician or practitioner about any of the following (check all boxes that apply):

1. Heart, Cardiovascular or Circulatory Disorder

- a. High Blood Pressure or Hypertension
- b. Chest Pain or Angina
- c. Heart Murmur, Mitral Valve Prolapse, Heart Valve Condition or Irregular Heartbeat
- d. Blood Clot, Embolism, Carotid Artery Blockage, Phlebitis or Edema
- e. Congenital Heart Condition
- f. Peripheral Artery or Vascular Disease (PAD)
- g. Other Cardiovascular, Circulatory or Heart Condition
- No to all Heart, Cardiovascular or Circulatory disorders**

2. Blood, Endocrine, Pituitary or Lymph Node Disorder

- a. Elevated Cholesterol or Triglycerides
- b. High or Low Blood Sugar or Sugar Intolerance
- c. Anemia or Hepatitis A, B, D, E or G
- d. Hemophilia, Hemochromatosis or Factor V Leiden
- e. Obesity
- f. Thyroid disorder or goiter
- g. Recurrence of Enlarged or Swollen Lymph Node
- h. Other Blood, Endocrine, Pituitary or Lymph Node Condition
- No to all Blood, Endocrine, Pituitary or Lymph Node disorders**

3. Digestive Disorder

- a. Gastroesophageal Reflux Disease (GERD), Gastritis or Heartburn
- b. Stomach Ulcer
- c. Irritable Bowel Syndrome (IBS), Chronic Diarrhea, Colitis or Ulcerative Colitis
- d. Diverticulitis, Diverticulosis, Hemorrhoids or Colon Polyps
- e. Jaundice or Pancreatitis
- f. Other Stomach, Liver, Pancreas, Spleen, Colon or Gallbladder Condition
- No to all Digestive disorders**

4. Genitourinary Disorder – Kidney, Bladder, Prostate, Urethra, Ureter

- a. Kidney or Bladder Infection, Protein or Blood in Urine
- b. Kidney stone
- c. Prostatitis, Enlarged Prostate or Elevated PSA
- d. Renal Insufficiency
- e. Other Genitourinary Condition
- No to all Genitourinary disorders**

5. Congenital or Developmental Disorder

- a. Cleft Palate or Cleft Lip
- b. Autism, Asperger's or Pervasive Development Disorder
- c. Developmental Disorder or Delay, Down's Syndrome or Mental Disability
- d. Club Foot/Feet
- e. Other Congenital or Developmental Condition
- No to all Congenital or Developmental disorders**

6. Cyst, Growth, Lump, Mass or Tumor

- a. Melanoma
- b. Cyst, Growth, Lump, Mass or Tumor
- No to all Cyst, Growth, Lump, Mass or Tumor conditions**

F HEALTH INFORMATION (continued)

SECTION F3 (continued): Within the past 5 years, has any person named on this application been diagnosed with, treated for, or consulted with a physician or practitioner about any of the following (check all boxes that apply):

7. Muscle, Bone, Joint, Immune System Disorder

- | | |
|---|--|
| <input type="checkbox"/> a. Back Pain, Neck Pain, Spine or Disc Condition | <input type="checkbox"/> g. Rotator Cuff Syndrome or Tear or Shoulder Condition |
| <input type="checkbox"/> b. Knee Injury or Condition | <input type="checkbox"/> h. Internal Fixation Device (screws, plates, pins), Prosthesis, Amputation or Joint Replacement |
| <input type="checkbox"/> c. Osteoarthritis, Gout, Bursitis, Tendonitis | <input type="checkbox"/> i. Other Muscle, Bone, Joint or Immune System Condition |
| <input type="checkbox"/> d. Fibromyalgia or Chronic Fatigue Syndrome | <input type="checkbox"/> No to all Muscle, Bone, Joint, Immune System disorders |
| <input type="checkbox"/> e. TMJ or Carpal Tunnel Syndrome | |
| <input type="checkbox"/> f. Connective Tissue Disorder | |

8. Brain or Nervous System Disorder

- | | |
|---|--|
| <input type="checkbox"/> a. Migraines or Recurrent Headaches | <input type="checkbox"/> f. Paralysis |
| <input type="checkbox"/> b. Epilepsy, Seizures, Tics or Tremors | <input type="checkbox"/> g. Cerebral Palsy |
| <input type="checkbox"/> c. Dizziness or Fainting | <input type="checkbox"/> h. Concussion, Head Trauma, Brain Injury or Memory Loss |
| <input type="checkbox"/> d. Transient Ischemic Attack (TIA) or Stroke | <input type="checkbox"/> i. Other Brain or Nervous System Condition |
| <input type="checkbox"/> e. Alzheimer's, Dementia or Parkinson's | <input type="checkbox"/> No to all Brain or Nervous System disorders |

9. Respiratory Disorder

- | | |
|--|---|
| <input type="checkbox"/> a. Asthma | <input type="checkbox"/> e. Shortness of Breath |
| <input type="checkbox"/> b. Allergies or Hay Fever | <input type="checkbox"/> f. Tuberculosis |
| <input type="checkbox"/> c. Chronic Bronchitis | <input type="checkbox"/> g. Other Respiratory Condition |
| <input type="checkbox"/> d. Sleep Apnea | <input type="checkbox"/> No to all Respiratory disorders |

10. Female Reproductive System Disorder

- | | |
|--|--|
| <input type="checkbox"/> a. Abnormal Pap Smear | <input type="checkbox"/> f. Menstrual Condition |
| <input type="checkbox"/> b. Abnormal Mammogram | <input type="checkbox"/> g. Multiple Miscarriages |
| <input type="checkbox"/> c. Infertility | <input type="checkbox"/> h. Cervical, Ovarian, Uterine or Vaginal Condition |
| <input type="checkbox"/> d. Endometriosis, Polycystic Ovarian Syndrome (PCOS), Pelvic Inflammatory Disease | <input type="checkbox"/> i. Other Female Reproductive Condition |
| <input type="checkbox"/> e. Uterine Fibroids | <input type="checkbox"/> No to all Female Reproductive System disorders |

11. Male Reproductive System Disorder

- | | |
|--|--|
| <input type="checkbox"/> a. Infertility | <input type="checkbox"/> c. Other Male Reproductive Condition |
| <input type="checkbox"/> b. Penile or Testicular Condition | <input type="checkbox"/> No to all Male Reproductive System disorders |

12. Sexually Transmitted Disease

- | | |
|--|---|
| <input type="checkbox"/> a. Genital Warts or Genital Herpes | <input type="checkbox"/> d. Other Sexually Transmitted Disease |
| <input type="checkbox"/> b. Human Papilloma Virus (HPV) | <input type="checkbox"/> No to all Sexually Transmitted Diseases |
| <input type="checkbox"/> c. Chlamydia, Gonorrhea or Syphilis | |

13. Mental, Emotional or Psychological Disorder

- | | |
|---|--|
| <input type="checkbox"/> a. Anxiety, Depression, Panic Disorder | <input type="checkbox"/> e. Psychiatric or Psychological Counseling or Therapy |
| <input type="checkbox"/> b. Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD) | <input type="checkbox"/> f. Obsessive Compulsive Disorder or Personality Disorder |
| <input type="checkbox"/> c. Anorexia or Bulimia | <input type="checkbox"/> g. Other Mental, Emotional or Psychological Condition |
| <input type="checkbox"/> d. Bipolar or Schizophrenia | <input type="checkbox"/> No to all Mental, Emotional or Psychological disorders |

14. Skin Disorder

- | | |
|--|--|
| <input type="checkbox"/> a. Acne | <input type="checkbox"/> d. Other Skin Condition |
| <input type="checkbox"/> b. Rosacea, Eczema or Psoriasis | <input type="checkbox"/> No to all Skin disorders |
| <input type="checkbox"/> c. Skin Cancer | |

15. Eye, Ear, Nose or Throat Condition

- | | |
|---|---|
| <input type="checkbox"/> a. Cataracts, Glaucoma, Retinitis, Retinal Tear or Blindness | <input type="checkbox"/> e. Deviated Nasal Septum, Recurrent Sinusitis |
| <input type="checkbox"/> b. Recurrent Ear Infections | <input type="checkbox"/> f. Recurrent Tonsillitis |
| <input type="checkbox"/> c. Hearing Loss | <input type="checkbox"/> g. Other Eye, Ear, Nose or Throat Condition |
| <input type="checkbox"/> d. Cochlear Implant | <input type="checkbox"/> No to all Eye, Ear, Nose or Throat conditions |

F HEALTH INFORMATION (continued)

F4 SECTION F4: Within the past 5 years, has any person named on this application:

- A. Been hospitalized? Yes No
- B. Been evaluated for or treated for alcoholism, chemical dependency, drug abuse? Yes No
- C. Been advised to have, or are considering, a consultation, surgery, treatment or testing which has not yet been performed? Yes No
- D. Had an MRI, CT scan, stress test, echocardiogram, electrocardiogram, X-ray or other diagnostic testing? Yes No
- E. Been seen by a medical provider for any health condition not already listed on this application (excluding common cold or flu)? Yes No
- F. Been advised by a medical provider to modify or restrict eating or drinking habits? Yes No
- G. Been declined coverage, charged an increased rate, or had benefits excluded from a health insurance policy because of a health condition? Yes No

F5 SECTION F5: If you checked any health conditions and/or checked "Yes" to any questions in sections F2-F4, please complete this section and provide us with complete details. Add additional pages if necessary.

| | | | | | |
|---------------------------|--------------------|---|-------------|-------------------------|----------------------|
| Question number & letter: | Person's name: | Treatment received: | | | Physician's name: |
| | Medical condition: | Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No | Onset date: | Complete recovery date: | Physician's address: |
| Question number & letter: | Person's name: | Treatment received: | | | Physician's name: |
| | Medical condition: | Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No | Onset date: | Complete recovery date: | Physician's address: |
| Question number & letter: | Person's name: | Treatment received: | | | Physician's name: |
| | Medical condition: | Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No | Onset date: | Complete recovery date: | Physician's address: |
| Question number & letter: | Person's name: | Treatment received: | | | Physician's name: |
| | Medical condition: | Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No | Onset date: | Complete recovery date: | Physician's address: |
| Question number & letter: | Person's name: | Treatment received: | | | Physician's name: |
| | Medical condition: | Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No | Onset date: | Complete recovery date: | Physician's address: |
| Question number & letter: | Person's name: | Treatment received: | | | Physician's name: |
| | Medical condition: | Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No | Onset date: | Complete recovery date: | Physician's address: |

F HEALTH INFORMATION (continued)

F6 SECTION F6: Please list the date and results of the last physical exam for all persons named on this application. For female applicants, please include date and result of last pap smear:

| | | | |
|------------------------|------------------|-------------------------|----------------------|
| Person's name: | Results of exam: | Blood pressure reading: | Physician's name: |
| Date of physical exam: | | Cholesterol reading: | Physician's address: |
| Person's name: | Results of exam: | Blood pressure reading: | Physician's name: |
| Date of physical exam: | | Cholesterol reading: | Physician's address: |
| Person's name: | Results of exam: | Blood pressure reading: | Physician's name: |
| Date of physical exam: | | Cholesterol reading: | Physician's address: |
| Person's name: | Results of exam: | Blood pressure reading: | Physician's name: |
| Date of physical exam: | | Cholesterol reading: | Physician's address: |
| Person's name: | Results of exam: | Blood pressure reading: | Physician's name: |
| Date of physical exam: | | Cholesterol reading: | Physician's address: |
| Person's name: | Results of exam: | Blood pressure reading: | Physician's name: |
| Date of physical exam: | | Cholesterol reading: | Physician's address: |

F7 SECTION F7: Please list all prescription medications filled in the last 12 months for any persons named on this application. Add additional pages if necessary.

| | | | | |
|--------------------|--|------------------------|--|---|
| Person's name: | Drug name: | | Generic? <input type="checkbox"/> Yes <input type="checkbox"/> No | Currently taking? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Medical condition: | Dosage: <input type="checkbox"/> mg <input type="checkbox"/> ml | Number taken each day: | Number of refills per year: | If "No", date stopped: |
| Person's name: | Drug name: | | Generic? <input type="checkbox"/> Yes <input type="checkbox"/> No | Currently taking? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Medical condition: | Dosage: <input type="checkbox"/> mg <input type="checkbox"/> ml | Number taken each day: | Number of refills per year: | If "No", date stopped: |
| Person's name: | Drug name: | | Generic? <input type="checkbox"/> Yes <input type="checkbox"/> No | Currently taking? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Medical condition: | Dosage: <input type="checkbox"/> mg <input type="checkbox"/> ml | Number taken each day: | Number of refills per year: | If "No", date stopped: |
| Person's name: | Drug name: | | Generic? <input type="checkbox"/> Yes <input type="checkbox"/> No | Currently taking? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Medical condition: | Dosage: <input type="checkbox"/> mg <input type="checkbox"/> ml | Number taken each day: | Number of refills per year: | If "No", date stopped: |

Primary Applicant's Name:

SECTION

G EFFECTIVE DATE OF COVERAGE

! Notes:

- Coverage must start on the 1st day of any month. Coverage can begin the day after the application is received by Medica.
- The effective date must be within 60 days of the application's signature date.
- 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:

1st

SECTION

H 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 authorize any hospital, clinic, institution, physician, insurance company, Intelliscript or other organization, institution or person to give Medica or any of its designees any and all records of information pertaining to medical history or services rendered to Us including, but not limited to, information relating to any Medica records or medical insurance claims, consultations or treatments; outpatient or inpatient hospital services; prescription information and lab work.

I understand that:

1. This information will be used for underwriting, 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, if approved, will be based upon the selection made in Section C, unless Medica has offered, and I have accepted in writing, 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.
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 (including information from my medical records) to my insurance broker should I choose to name one. This includes information related to any applicant listed within this application.
8. For individuals age 19 and older, if approved for coverage, a pre-existing condition limitation may apply. If continuous qualifying health coverage has been maintained, this pre-existing condition limitation is in effect for 12 months, but will be reduced based upon length of previous qualifying coverage. If continuous qualifying health coverage has not been maintained, this pre-existing condition limitation is in effect for the first 12 months.

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:

Signature of Primary Applicant:

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:

X

Signature of Additional Applicant Age 18 or Older: Date:

X

Signature of Additional Applicant Age 18 or Older: Date:

X

Signature of Additional Applicant Age 18 or Older: Date:

X

Primary Applicant's Name:

! **Note:** Finished filling out your application? Be sure you have all of 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 and Benefits 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. Additional pages for Section F, Health Information (*if necessary*)
5. ACH form (*if you are enrolling in automatic payment from your checking account*)

Return completed applications to: **or Fax to:**
 Medica Insurance Company 952-992-2511
 Mail Route CP312
 PO Box 9310
 Minneapolis, MN 55440-9310

I 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: X | Date: | Agent number: |
| Print agent's name: | Telephone number: + + | |

J 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.



Mail Route CP312, PO Box 9310, Minneapolis, MN 55440-9310

© 2011 Medica. Medica® is a registered service mark of Medica Health Plans. "Medica" refers to the family of health plan businesses that includes Medica Health Plans, Medica Health Plans of Wisconsin, Medica Insurance Company, Medica Self-Insured, and Medica Health Management, LLC.

Medica Symphony® is a registered service mark of Medica Health Plans. Medica SoloSM and Medica EncoreSM are service marks of Medica Health Plans.

SECTION

C PLAN AND BENEFITS SELECTION

Plan selection: Select either Medica SoloSM, Medica EncoreSM, Medica Symphony®, Medica Symphony® for HSA, Medica Direct Basic or Medica Direct Standard and complete the additional information below it.

Note: You must complete each box within your selected plan's column. Only complete information underneath your chosen plan.

| Medica Solo <input type="checkbox"/> | Medica Encore <input type="checkbox"/> | Medica Symphony <input type="checkbox"/> | Medica Symphony for HSA <input type="checkbox"/> |
|---|--|--|---|
| Answer 3 questions below | Answer 4 questions below | Answer 4 questions below | Answer 2 questions below |
| 1. Choose your plan coverage and select your deductible level: | | | |
| 80% one-person coverage. Select deductible level: <input type="checkbox"/> \$3,050 <input type="checkbox"/> \$6,100 <input type="checkbox"/> \$9,150 <input type="checkbox"/> \$12,200 100% one-person coverage. Select deductible level: <input type="checkbox"/> \$3,050 <input type="checkbox"/> \$6,100 <input type="checkbox"/> \$9,150 <input type="checkbox"/> \$12,200 | 100% one-person coverage. Select deductible level: <input type="checkbox"/> \$4,050 <input type="checkbox"/> \$6,600 <input type="checkbox"/> \$9,150 100% two-person coverage. Select deductible level: <input type="checkbox"/> \$6,100 <input type="checkbox"/> \$7,600 <input type="checkbox"/> \$9,150 | 100% one-person coverage. Select deductible level: <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$3,550 <input type="checkbox"/> \$5,050 <input type="checkbox"/> \$7,100 <input type="checkbox"/> \$10,150 100% family coverage. Select deductible level: <input type="checkbox"/> \$4,050 <input type="checkbox"/> \$7,100 <input type="checkbox"/> \$10,150 <input type="checkbox"/> \$14,200 <input type="checkbox"/> \$20,300 | 80% one-person coverage. Select deductible level: <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$3,050 <input type="checkbox"/> \$5,050 80% family coverage. Select deductible level: <input type="checkbox"/> \$3,050 <input type="checkbox"/> \$5,550 <input type="checkbox"/> \$8,100 100% one-person coverage. Select deductible level: <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$3,350 <input type="checkbox"/> \$4,650 <input type="checkbox"/> \$6,000 100% family coverage. Select deductible level: <input type="checkbox"/> \$4,050 <input type="checkbox"/> \$7,100 <input type="checkbox"/> \$9,650 <input type="checkbox"/> \$12,100 |
| 2. Select your office visit copayment option: | | | |
| <i>Your copayment is tied to your deductible level</i> | <input type="checkbox"/> Option A: \$20 copayment <input type="checkbox"/> Option B: \$40 copayment | <input type="checkbox"/> Option A: \$30 copayment <input type="checkbox"/> Option B: \$60 copayment | <i>Not applicable</i> |
| 3. Mental health and substance abuse coverage option: Choose if you would like to keep or remove the mental health and substance abuse coverage currently offered in your selected plan. This option is only available at the time of your initial application. This option will be in force for the duration of your policy. <i>Removing coverage reduces your monthly rate.</i> | | | |
| <input type="checkbox"/> Keep coverage <input type="checkbox"/> Remove coverage | <input type="checkbox"/> Keep coverage <input type="checkbox"/> Remove coverage | <input type="checkbox"/> Keep coverage <input type="checkbox"/> Remove coverage | <input type="checkbox"/> Keep coverage <input type="checkbox"/> Remove coverage |
| 4. Prescription drug coverage option: Choose if you would like to increase your prescription drug coverage. This option is only available at the time of your initial application. This option will be in force for the duration of your policy. <i>Choosing this option increases your monthly rate.</i> | | | |
| <input type="checkbox"/> Keep Tier 1-only coverage <input type="checkbox"/> Increase coverage to include Tier 2 and 3 | <input type="checkbox"/> Keep Tier 1-only coverage <input type="checkbox"/> Increase coverage to include Tier 2 and 3 | <input type="checkbox"/> Keep Tier 1-only coverage <input type="checkbox"/> Increase coverage to include Tier 2 and 3 | <i>Not applicable</i> |
| <input type="checkbox"/> Medica Direct Basic | | | |
| <input type="checkbox"/> Medica Direct Standard | | | |