MEDICA®

MINNESOTA

Medica Direct HSA℠ for Individuals

Medica Direct Value℠ for Individuals

Change Form

Medica Insurance Company

Form # MN-CMB-CHNG 07-101-01

MEDICA®

MINNESOTA

CHANGE FORM

Medica Direct for Individuals℠

Send completed form to:

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

Please print clearly with a blue or black pen.

A. SUBSCRIBER INFORMATION (This section must be completed)

First Name	M.I.	Last Name	Social Security Number

Current Medica I.D. Number	Home Telephone	Work Telephone
–	( )	( )

B. ADDRESS CHANGE (If applicable)

Change Address from:
Street Address City State Zip

Change Address to:
Street Address City State Zip

C. NAME CHANGE (If applicable)

Change Name from: **Change Name to:**

D. MEMBER ADDITIONS AND DELETIONS (If applicable)

Addition(s) of dependent child coverage*:

Reason:

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

Effective date of addition: / /

* **Note:** Spouses, or other types of dependents, can only be added by completing a new application form which is subject to underwriting.

Termination(s) of coverage:

Reason (check one):

❑ Terminate all coverage ❑ Dependent ineligible
❑ Death ❑ Other:

Effective date of termination**: / /

** **Note:** This date must be the end of a month following the date Medica receives this form, provided that this date is no more than 60 days following the signature date on this change form.

#	Change	First Name / M.I.	Relationship	Birth Date
1	❑ Add ❑ Terminate	**First Name** **M.I.**	**Relationship**	**Birth Date**
		Last Name	**Sex** ❑ Female ❑ Male	**Social Security Number**
2	❑ Add ❑ Terminate	**First Name** **M.I.**	**Relationship**	**Birth Date**
		Last Name	**Sex** ❑ Female ❑ Male	**Social Security Number**
3	❑ Add ❑ Terminate	**First Name** **M.I.**	**Relationship**	**Birth Date**
		Last Name	**Sex** ❑ Female ❑ Male	**Social Security Number**

E. OPTIONAL BENEFIT CHANGE (If applicable)

First Dollar Preventive Coverage Election (for HSA plans only)

❑ I want to **include,** at 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 covered under the policy. I also understand that this election will result in an increase in my monthly premium, and will be effective the first of the month following receipt by Medica and will be in force for the duration of the policy.

F. POLICY CHANGE (If applicable)

Note: There are some policy changes, such as reductions in deductible or maximum out-of-pocket amounts that can **not** be made without completing a separate application subject to underwriting. Certain policy changes may cause annual benefit limits including deductible, out-of-pocket amounts and any other benefit limits to start over. Certain benefits may also be added or deleted when you request a policy change from one Medica Direct for Individuals product to another. To verify the plan coverage options that you may have and learn about any benefit changes or other requirements, please contact your broker or call a Medica sales representative at 952-992-2080 or 1-800-670-5935.

Requested effective date of policy change: I understand that this change will be effective the later of:
(1) the first of the following month if received by last day of the month by Medica, or
(2) the first of my designated month (____________________), as long as this form is received by Medica prior to the requested effective date and it is not more than 60 days from my signature date.

Medica Direct HSA Plan

Please change my policy deductible plan to:

80% Plan
❑ $1,400 Individual Coverage/$2,800 Family (2 or more) Coverage
❑ $1,800 Individual Coverage/$3,650 Family (2 or more) Coverage

100% Plan
❑ $1,800 Individual Coverage/$3,650 Family (2 or more) Coverage
❑ $2,400 Individual Coverage/$4,500 Family (2 or more) Coverage
❑ $2,850 Individual Coverage/$5,500 Family (2 or more) Coverage
❑ $3,500 Individual Coverage/$7,000 Family (2 or more) Coverage

If you are requesting a change **from** a Medica Direct Value for Individuals plan **to** a Medica Direct HSA for Individuals plan, please complete the information below.

Mental Health Coverage Election: ***(Please complete only if you are moving to a Medica Direct HSA plan from a Medica Direct Value plan that has a $150 or $500 deductible.)*** I want to continue to **include,** at an additional cost, benefits for treatment and consultation of diagnosis and treatment of mental disorders including inpatient and outpatient services. I understand this election applies to all persons currently covered under my Medica Direct Value for Individuals plan and may be made only at the time of this change **from** a Medica Direct Value for Individuals $150 or $500 deductible plan **to** a Medica Direct HSA for Individuals plan. This election will be in force for the duration of my policy . . . . ❑ Yes ❑ No

Mental Health Coverage Election: ***(Please complete only if you are moving to a Medica Direct HSA plan from a Medica Direct Value plan that has a deductible that is $1,000 or greater.)*** I understand that when I change from a Medica Direct Value plan with a deductible of $1,000 or greater, the mental health coverage election that I made at the time of the initial Medica Direct Value application will carry forward to the Medica Direct HSA plan that I have selected. __________ (please initial)

Chemical Dependency Coverage: I understand that chemical dependency coverage, including treatment or consultation for alcoholism, chemical dependency or drug addiction, is **automatically part** of the Medica Direct HSA for Individuals benefit package. I understand that this change applies to all persons currently covered under my Medica Direct Value for Individuals plan. __________ (please initial)

Medica Direct Value Plan

Please change my policy deductible plan to:

❑ $500 ❑ $1,000 ❑ $1,500 ❑ $2,500 ❑ $5,000

If you are requesting a change **from** a Medica Direct HSA for Individuals plan **to** a Medica Direct Value for Individuals plan, please complete the information below.

Mental Health Coverage Election: I understand that when I change from a Medica Direct HSA for Individuals plan to a Medica Direct Value for Individuals plan, the mental health coverage election that I made for the Medica Direct HSA plan will carry forward to the Medica Direct Value plan that I have selected. __________ (please initial)

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 currently covered under my Medica Direct for Individuals plan and may be made only at the time of this initial change from a Medica Direct HSA for Individuals plan to a Medica Direct Value for Individuals plan . . . . ❑ Yes ❑ No

First Dollar Preventive Coverage: I understand that when I change **from** a Medica Direct HSA for Individuals plan **to** a Medica Direct Value for Individuals plan, I will no longer have first dollar preventive coverage for myself and all persons covered under this plan. __________ (please initial)

G. SUBSCRIBER AUTHORIZATION (Read this section, date and sign the form)

I understand and agree that 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 (or include certain optional benefits) without providing a health history and application. I understand this election applies to all persons covered under the policy.

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 to the best of my knowledge. I understand and agree that any omissions or incorrect statements knowingly made by me on this form may invalidate my or my dependent's coverage.

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

Subscriber's Signature: X ______________________ **Date:** ____/____/____

I authorize Medica to make the changes to my policy as requested by the Subscriber and identified in this Change Form.

X ______________________ ____________ X ______________________ ____________

Signature(s) of Other Dependents 18 or Over — **Date** — **Signature of Spouse or Other Insured** — **Date**

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

OFFICE USE ONLY

Eff. Date of Change	Reviewed by Date	New Plan Code	PE Mos.	Premium Change	Rollover
/ /				❑ Y ❑ N	❑ Y ❑ N

MEDICA®

Mail Route CP320
PO Box 9310, Minneapolis, MN 55440-9310

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