

MEDICA®

SOUTH DAKOTA

**Medica Direct
HSASM
for Individuals**

Application Form.....

IMPORTANT INFORMATION ABOUT YOUR APPLICATION

1. Please review your application to assure that every question has been answered.
2. Questions in Section E pertain to all applicants. To avoid unnecessary delays, please provide a complete explanation of all “yes” answers. Space is provided under Section 8. Please indicate whether any checkups, physicals, exams, lab work, or X-rays you’ve listed were routine or due to symptoms of illness or injury. Also indicate if the results were normal or if any problems were noted. For each medical condition, illness, or injury, include the onset date and the complete recovery date when appropriate.
3. If approved by the 20th of the month, your application will become effective on the first day of the month following your approval, or if possible, your requested date. See Section C, question 5. Medica will notify you as to whether you have been approved and your effective date. Processing time of your application is approximately 3–4 weeks.
4. Submit your premium payment along with your application.
5. 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.
6. Please be sure to indicate the deductible plan you are applying for in Section C, question 1.

ANY MISSING INFORMATION WILL CAUSE DELAYS IN PROCESSING YOUR APPLICATION AND MAY DELAY THE EFFECTIVE DATE OF COVERAGE.

If you have questions or need assistance completing the application, please contact a Medica Sales Service Specialist at 952-992-2080 or 1-800-670-5935 between 8:00 a.m.–5:00 p.m., Monday through Thursday, and 9:00 a.m.–5:00 p.m. on Friday.

Thank you for your interest in Medica.

Medica Direct HSASM for Individuals APPLICATION FORM

PLEASE TYPE or PRINT CLEARLY
AND PRESS FIRMLY.

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A. APPLICANT INFORMATION

1) Applicant's Name (<i>Last, First, Middle</i>)			2) Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	
3) Applicant's Home Address (<i>Street, City, County, State, ZIP</i>)			4) Billing Address (<i>if different from #3</i>)	
5) Home Telephone No. ()	6) Work Telephone No. ()	7) Cellular Telephone No. ()		
8) Are you a permanent resident of South Dakota currently residing in South Dakota? <input type="checkbox"/> Yes <input type="checkbox"/> No If "no," please explain _____				
9) Are you a permanent United States resident? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes," how long? _____ years				
10) Occupation (<i>Applicant</i>)	Company Name	Hours Worked Per Week _____ <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time	Work Telephone Number ()	
Duties		Self-Employed <input type="checkbox"/> Yes <input type="checkbox"/> No	Covered by Worker's Compensation <input type="checkbox"/> Yes <input type="checkbox"/> No	
11) Occupation (<i>Spouse</i>)	Company Name	Hours Worked Per Week _____ <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time	Work Telephone Number ()	
Duties		Self-Employed <input type="checkbox"/> Yes <input type="checkbox"/> No	Covered by Worker's Compensation <input type="checkbox"/> Yes <input type="checkbox"/> No	
12) Reason for Application (complete one):				
<input type="checkbox"/> I am a new applicant presently not covered under a Medica policy.				
<input type="checkbox"/> I presently have Medica coverage. I am covered under I.D. number				
<input type="checkbox"/> I presently have Medica Direct HSA for Individuals coverage and want to add my dependent(s) listed below. My policy identification (I.D.) number is				

B. APPLICANT AND DEPENDENT INFORMATION

1) Starting with yourself, list each dependent for whom application is being made. Add additional page if more space is needed.

First name	Middle initial	Last name	Social Security No.	Sex	Relationship to applicant	Birth date mo/day/yr	State of birth	Height	Present weight	Weight one year ago
				M F	(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.

2) For any dependents age 25–29 listed in item 1 above, complete the following:

Name of dependent	Full-time student	Anticipated graduation date	School name
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		

3) Does any proposed insured live outside the above household? Yes No
If "Yes," explain: _____

4) Are any household members not to be covered here? Yes No
If "Yes," please explain why: _____

Applicant's Name: _____

E. HEALTH INFORMATION

Check every Yes or No box and circle the medical condition(s) for all questions answered Yes, for you and your family members applying for coverage. For each question answered "Yes," please complete Section 8.

Section 1: Has any proposed insured in the last 10 years had any diagnosis of, received treatment for or consulted with a physician concerning:

- | | Yes | No |
|--|--------------------------|--------------------------|
| a. Heart disorders, including but not limited to, chest pain, heart murmur, angina, high blood pressure, congestive heart failure, or cardiovascular disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| If "Yes," last cholesterol reading? _____ (date _____). Last blood pressure reading? _____ (date _____). | | |
| b. Circulatory disorders, including but not limited to, peripheral vascular disease, varicose veins, varicose ulcer, phlebitis, anemia, blood clots or other related disorders? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Respiratory disorders, including but not limited to, tuberculosis, asthma, allergies, hay fever, emphysema, chronic bronchitis, lung or respiratory disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Nervous system disorders, including but not limited to, stroke, 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, colitis, hepatitis,* chronic diarrhea, jaundice, cirrhosis, or any disorder of the liver, gallbladder, stomach, intestine, or rectum? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Renal disorders, including, but not limited to, kidney, bladder, prostate, or urinary disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Musculoskeletal disorders including, but not limited to, arthritis, rheumatism or any disorder of the joints, muscles or bones, any knee, neck, back or spinal trouble, neuritis, sciatica, scoliosis, 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, or sexually transmitted disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Metabolic disorders, including but not limited to, diabetes or sugar, albumin or blood in the urine? | <input type="checkbox"/> | <input type="checkbox"/> |
| If "Yes," date of diagnosis _____, last A-1 C reading _____ and date _____, or blood sugar reading _____ and date? _____ | | |
| j. Eating disorders, unexplained weight loss/gain, fever, enlarged lymph nodes, skin lesions, or any other related disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Cancer, tumor, cysts, or growth of any kind? | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Immune system disorders, including but not limited to, HIV-positive, AIDS, lupus, collagen disease, scleroderma, or any other connective tissue disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| m. Blood disorders? | <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, hyperactivity, nervous, anxiety, attention deficit, or personality disorders, including counseling or hospitalization? | <input type="checkbox"/> | <input type="checkbox"/> |
| p. Glandular disorders, including but not limited to thyroid, adrenal, pituitary, pancreas, or lymph node/gland enlargement? | <input type="checkbox"/> | <input type="checkbox"/> |
| q. Congenital 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, or growth? | <input type="checkbox"/> | <input type="checkbox"/> |
| s. General fatigue, malaise, mononucleosis, or Epstein-Barr Syndrome? | <input type="checkbox"/> | <input type="checkbox"/> |

Section 2: Has any proposed insured ever:

- | | | |
|--|--------------------------|--------------------------|
| a. In the last five years, been evaluated for, treated for, or joined any organization for alcoholism/chemical dependency; consumed alcohol to excess or used drugs improperly without physician approval or been convicted for or had a driver's license suspended for DWI/DUI or moving violation? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Been advised by a medical professional to modify or restrict eating or drinking habits for health purposes? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Been hospitalized (within the past five years)? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Been advised to have surgery or treatment not yet done? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Had any medical treatment, diagnosed or treated health impairment or congenital anomaly not already noted in this enrollment form? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Used tobacco products during the 36 months immediately preceding the date of this application? | <input type="checkbox"/> | <input type="checkbox"/> |
| If "Yes," how much per day? _____ If quit, date? _____ | | |
| g. Had an electrocardiogram, laboratory or diagnostic test or x-ray (other than dental)? | <input type="checkbox"/> | <input type="checkbox"/> |

Section 3:

- | | | |
|---|--------------------------|--------------------------|
| a. Are any proposed insureds currently pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| If "Yes," list due date and if any complications or multiple births are expected. _____ | | |
| b. Is any person not named on the application now pregnant by any proposed insured applying for coverage or is any person applying for coverage anticipating the adoption of a child? | <input type="checkbox"/> | <input type="checkbox"/> |

Section 4:

- | | | |
|---|--------------------------|--------------------------|
| a. Does any proposed insured have any fixation/prosthetic devices present, including but not limited to, plates, screws, pins, implants, shunts, pacemaker, or valve replacement? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. In the last five years, have any of the proposed insured 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, rock or mountain climbing? | <input type="checkbox"/> | <input type="checkbox"/> |

Section 5: Is any proposed insured currently disabled, hospitalized or on medical leave?

Applicant's Name: _____

E. HEALTH INFORMATION continued

Section 6: Please list the date of last physical exam for all proposed insureds. If female, please also list date of last Pap smear and result.

Person's name	Date of exam	Name & address of physician	Type of exam	Pap Smear results

Section 7: Please list all medications taken for any proposed insured in the past 12 months. Add additional page if you need more space.

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

Section 8: If you have answered "Yes" to any questions in Sections E1 through E5, please complete this section. Give complete details. Add an additional page if you need more space.

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

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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