

MEDICA®

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SOUTH DAKOTA

**Medica Prelude<sup>SM</sup>**

*Application Form.....*



**E. AUTHORIZATION & REPRESENTATION – Read this section, date and sign the application.**

**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 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. I have the right to see and correct my personal information in accordance with the law;
5. I have the right to review Medica's Privacy Notice before signing this application and to request a copy at any time.
6. 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.
7. For individuals, if approved for coverage, a pre-existing condition limitation will apply.

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 Applicant	Date	Signature of Spouse or Other Insured (If proposed to be insured)	Date
Signature(s) of Other Dependents 18 or Over (If proposed to be insured)	Date	Please provide signature below if the Primary Applicant is under age 18:	
		Signature of Guarantor, Parent or Legal Guardian	Date

**F. AGENTS**

Application was completed by  **applicant**  **agent**. I certify that I have reviewed this application. If this 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.

<b>X</b>	( )	( )	Date
Agent's Signature	Print Agent's Name & Number	Agent's Phone Number	

**G. FOR OFFICE USE ONLY**

Date Received	Plan Code	Effective Date	Term Date	Payment ID	Amount
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*A person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.*

**MEDICA®**

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

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