OMB No. 0938-1378
Expires: 7/31/2023

SOUTH MINNESOTA

Medica Advantage Solution® (PPO) Plan

2023 Enrollment Application Form

A	PLEASE READ BEFORE COMPLETING YOUR APPLICATION

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan.

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Advantage Plan, you must also have both Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance).

When do I use this form?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit Medicare.gov to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items in Section 1, 2, 3 and 8. The items in Section 4, 5, 6 and 7 are optional — you can't be denied coverage because you don't fill them out.

Individuals experiencing homelessness

• If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

Medica®

A PLEASE READ BEFORE COMPLETING YOUR APPLICATION

Reminders:

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium (if your plan has a premium). You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.
- Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare plan options, as well as medical assistance through the state Medicaid program and the Medicare Savings Program.
- If you are getting assistance from a sales agent, broker or other individual employed by or contracted with Medica, he/she may be paid based on your enrollment in a Medica Plan.
- To enroll, please make sure you have completed and forwarded all necessary information to Medica. Complete all required sections of the application in full. Missing or incomplete information may cause a delay in the effective date of your coverage. Use a black or blue pen and print firmly.

What happens next?

Send your completed and signed form to:

Mail	Fax	Securely Upload
Medica PO Box 267008 Weston, FL 33326	1 (800) 294-5196	Medica.com/EnrollmentUpload

Once they process your request to join, they'll contact you.

How do I get help with this form?

If you have any questions concerning your application, please contact Medica at 1 (800) 918-2416 (TTY: 711) from 8 a.m.-8 p.m. CT, seven days a week.

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1 (877) 486-2048.

If you need information in an accessible format or language, please contact Medica at 1 (800) 918-2416 (TTY: 711) from 8 a.m.-8 p.m. CT, seven days a week.

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All fields on this page are required (unless marked optional).

1 PERSONAL INFORMATION (REQUIRED)

Legal First Name	Middle Initial	Last Name

Gender	Birthdate
❍ Male ❍ Female	_ _ _ _ / _ _ _ _ / _ _ _ _ _ _ _ _ (M M / D D / Y Y Y Y)
Primary Telephone (*With area code)*	Secondary Telephone (*With area code)*
(_ _ _ _) _ _ _ _ - _ _ _ _ _ _ _	(_ _ _ _) _ _ _ _ - _ _ _ _ _ _ _

Permanent Residence Address

Street

City	State	Zip Code	County

Mailing Address *(If different than Permanent Resident Address)*

Street

City	State	Zip Code	County

Email Address
(Optional – By providing your email, you agree Medica may send you communications about your plan.)

2 MEDICARE INFORMATION (REQUIRED)

Your enrollment form cannot be processed without this information.

Please take out your red, white and blue Medicare card to complete this section. You may:

- Fill out this information as it appears on your Medicare card; **OR**
- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (As it appears on your Medicare card)

Medicare Number

Is Entitled To	**Effective Date (mm/dd/yyyy)**
HOSPITAL (Part A):	_____
MEDICAL (Part B):	_____

You must have Medicare Part A and B to join a Medicare Advantage plan.

3 EFFECTIVE DATE AND PLAN SELECTION (REQUIRED)

I request an effective date for the first day of __ __ , 20__ __.
M M Y Y

I request to enroll in the following plan. Please check one below.

SOUTH MINNESOTA
You must reside in one of the following counties: Big Stone, Blue Earth, Brown, Cottonwood, Dodge, Faribault, Fillmore, Freeborn, Houston, Jackson, Lac Qui Parle, Lincoln, Lyon, Martin, Mower, Murray, Nicollet, Nobles, Olmsted, Redwood, Steele, Wabasha, Waseca, Watonwan or Winona county.

Medical & Part D Coverage:

❍ Medica Advantage Solution H8889-008 (PPO): $19.00/month

❍ Medica Advantage Solution H8889-004 (PPO): $134.00/month

Medical Coverage:

❍ Medica Advantage Solution H8889-009 (PPO): $0.00/month

4 ADDITIONAL QUESTIONS (OPTIONAL)

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

4a. Do you have health coverage through you or your spouse's current or former employer?

❍ Yes
❍ No

If you answered **YES**, please provide us with the following information.

Employer Name	Employer Address
Policyholder Name	Policy Number

4b. Some individuals may have other drug coverage, including other private insurance such as through an employer or spouse's employer, TRICARE, Federal Employee health benefits coverage, VA benefits or State Pharmaceutical Assistance Programs.

Do you or will you have other prescription drug coverage in addition to Medica Advantage Solution?

❍ Yes
❍ No

If you answered **YES**, please list your other coverage and your identification (ID) number(s) for this coverage.

Name of Other Coverage	ID Number	Group Number

4c. Please choose a Primary Health System (PHS) provider from which you receive care or anticipate to receive care. If you do not wish to choose a PHS or if your provider is not part of ones listed, you may choose "unassigned." Your selection of a Primary Health System does not limit you from receiving care from other network providers. To find out if your provider is part of a PHS, you may reference the directory at Medica.com/AdvantageSolutionProviders.

For plan H8889-004 (PPO), H8889-008 (PPO) or H8889-009 (PPO):

❍ Allina Health
❍ Avera Health
❍ Mayo Clinic
❍ Mayo Clinic Health System
❍ Olmsted Medical Center
❍ Sanford
❍ Winona Health
❍ Unassigned

5 PLEASE CAREFULLY READ THE FOLLOWING STATEMENTS (OPTIONAL)

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from Oct. 15 through Dec. 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the circle if the statement applies to you. By checking any of the following circles you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

❍ I am new to Medicare.

❍ Current Medicare Cost or Medicare Advantage plan is not renewing.

❍ Leaving or left employer or union coverage on __ / __ / __ (date).

❍ Recent change in Medicaid (newly enrolled, change in level of Medical Assistance or lost Medicaid) __ / __ / __ (date).

❍ I recently was released from incarceration. I was released on __ / __ / __ (date).

❍ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on __ / __ / __ (date).

❍ I recently obtained lawful presence status in the United States. I got this status on __ / __ / __ (date).

❍ Enrolled in a plan by Medicare (or my state) and want to choose a different plan. My enrollment in that plan started on __ / __ / __ (date).

❍ Have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.

❍ Recent change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, change in level of Extra Help or lost Extra Help) __ / __ / __ (date).

❍ Recently enrolled in or lost a State Pharmacy Assistance Program.

❍ Losing or lost prescription drug coverage on __ / __ / __ (date).

❍ Enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).

❍ Permanent residence changed; moved from _____ / ____ or _____ on __ / __ / __ (date).

County State Country

❍ Moving into, live in or moved out of a Long-Term Care Facility on __ / __ / __ (date).

❍ Left a Program of All-Inclusive Care for the Elderly (PACE) on __ / __ / __ (date).

❍ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on __ / __ / __ (date).

❍ Weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA)). One of the other statements here applies, but was unable to make enrollment because of natural disaster.

6 PLEASE READ AND ANSWER THESE QUESTIONS (OPTIONAL)

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

6a. Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ❍ No, not of Hispanic, Latino/a, or Spanish origin
- ❍ Yes, Mexican, Mexican American, Chicano/a
- ❍ Yes, Puerto Rican
- ❍ Yes, Cuban
- ❍ Yes, another Hispanic, Latino/a, or Spanish origin
- ❍ **I choose not to answer.**

6b. What's your race? Select all that apply.

- ❍ American Indian or Alaska Native
- ❍ Asian Indian
- ❍ Black or African American
- ❍ Chinese
- ❍ Filipino
- ❍ Guamanian or Chamorro
- ❍ Japanese
- ❍ Korean
- ❍ Native Hawaiian
- ❍ Other Asian
- ❍ Other Pacific Islander
- ❍ Samoan
- ❍ Vietnamese
- ❍ White
- ❍ **I choose not to answer.**

7 PREMIUM PAYMENT METHOD (OPTIONAL)

Please do not submit payment with your application.

You can pay your monthly plan premium, including any late enrollment penalty that you currently have or may owe, by mail or Electronic Funds Transfer (EFT) each month. **You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.**

Note: People with limited incomes may qualify for *Extra Help* to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles and coinsurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this *Extra Help*, contact your local Social Security office or call Social Security at 1 (800) 772-1213. TTY users should call 1 (800) 325-0778. You can also apply for *Extra Help* online at www.SocialSecurity.gov/PrescriptionHelp.

If you qualify for *Extra Help* with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or RRB. DO NOT pay Medica the Part D-IRMAA.

Please choose a payment method (if you don't select a payment method, you will receive a bill each month):

❍ Monthly invoicing

❍ Monthly automatic withdrawals from your checking or savings account

Withdrawals take place on or about the third day of each month.

Account Type:	Account Holder Name
❍ Checking (attach a voided check) ❍ Savings (attach a deposit slip)	

❍ Social Security or Railroad Retirement Board deduction

The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will not include all premiums due from your enrollment effective date up to the point withholding begins. **We will send you a paper invoice for those months before the deduction starts.** If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.

I get my monthly benefits from: ❍ Social Security ❍ RRB

Please Read This Important Information

If you currently have health coverage from an employer or union, joining Medica Advantage Solution may affect your employer or union health benefits. You could lose your employer or union health coverage if you join Medica Advantage Solution. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

8 SIGN & DATE (REQUIRED)

Important: Please read and sign below.

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Medica Advantage Solution.
- By joining this Medicare Advantage Plan: 1) I authorize Medica, its claims administrator, the Centers for Medicare and Medicaid Services (and its designee(s)), health plans, brokers of record, providers and any other person or entity to share my health information (except for psychotherapy notes, or chemical dependency records, unless permitted by law) with each other as is necessary for treatment, payment and health care operations; and 2) I acknowledge that Medica will share my information, including my prescription drug event data, with Medicare, who may use it to track my enrollment, to make payments, for research, and other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below).
- Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage in Canada and Mexico. Services authorized by Medica and other services contained in my Medica Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered.
- I understand that when my Medica Advantage Solution. coverage begins, I must get all of my medical and prescription drug benefits from Medica Advantage Solution. Benefits and services provided by Medica Advantage Solution and contained in my Medica Advantage Solution "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Medica will pay for benefits or services that are not covered.

I understand that my signature (or the signature of the person authorized to act on my behalf under state law where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that 1) this person is authorized under state law to complete this enrollment and 2) documentation of this authority is available upon request by Medica or by Medicare.

X _____ ___ / ___ / ___
Applicant or Authorized Representative Signature — Today's Date

If you are the authorized representative, you must provide the following information:

Name:	Phone Number:
Address:	Relationship to Enrollee:

AGENT USE ONLY

_____ _____
Agent Printed Name — ID Number

X _____ (____) ____ - _____ __ __ / __ __ / __ __ __ __
Agent Signature — Agent Telephone — (M M / D D / Y Y Y Y) Agent's Receipt Date

PO Box 9310, Minneapolis, MN 55440-9310

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.