KANSAS, MISSOURI AND OKLAHOMA RESIDENTS

Medica Prime Solution® (Cost) Plan

2023 Enrollment Application Form — Thrift, Core, or Premier

A	PLEASE READ BEFORE COMPLETING YOUR APPLICATION

- Please consult the Summary of Benefits for enrollment requirements and details on the plan. You may choose **Thrift, Core, or Premier**. You must continue to pay your Medicare Part B premium.
- If you have any questions concerning your application, please contact Medica at **1 (800) 918-2143** (TTY: **711**) from 8 a.m.-8 p.m. CT, seven days a week.
- 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 Medica Prime Solution.
- Medica Prime Solution policies provide an anticipated loss ratio of 78%. This means that on average, no less than $ 78.00 of every $100.00 in premium will be returned as benefits over the life of the policy.
- To enroll, please make sure you have completed and forwarded all necessary information to Medica. Complete all sections of the application in full. Please note, section 6 is optional. Missing or incomplete information may cause a delay in the effective date of your coverage. Use a black or blue pen and print firmly.

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

Return completed applications one of three ways:

Mail	Fax	Securely Upload
Medica PO Box 740110 Atlanta, GA 30374-0110	1 (855) 250-2166	Medica.com/EnrollmentUpload

2023 Medica Prime Solution® Enrollment Application Form

1 PERSONAL INFORMATION

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

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 B to join a Medicare Cost plan.

3	EFFECTIVE DATE AND PLAN SELECTION

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

Note: You must continue to pay your Part B premium.

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

THRIFT, CORE, OR PREMIER
You must reside in one of the following counties:

Kansas: Barber, Butler, Chase, Chautauqua, Coffey, Cowley, Elk, Graham, Greenwood, Harper, Harvey, Jackson, Jefferson, Jewel, Kingman, Lincoln, Lyon, Marion, Mitchell, Morris, Norton, Osage, Ottawa, Phillips, Pottawatomie, Republic, Smith, Stafford, Wabaunsee, Washington, or Woodson.

Missouri: Barry, Barton, Jasper, McDonald, Newton, or Vernon.

Oklahoma: Adair, Alfalfa, Delaware, Grant, Kay, Major, Noble, or Ottawa.

Medical Only Coverage:
❍ Thrift: $40.00/month
❍ Core: $76.00/month
❍ Premier: $130.00/month

4 PLEASE READ AND ANSWER THESE IMPORTANT QUESTIONS

This information is required to process your application and is NOT used for health screening.

4a. Do you have End-Stage Renal Disease (ESRD)?

❍ Yes
❍ No

If you answered **YES** and you do not need regular dialysis anymore, or have had a successful kidney transplant, **please attach a note or records from your doctor** showing you do not need dialysis or have had a successful kidney transplant.

4b. Do you or your spouse work?

❍ Yes
❍ No

4b. Do you have health coverage through your 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

4c. Are you enrolled in your state Medicaid program?

❍ Yes
❍ No

If you answered YES, please provide your Medicaid number: _____

4d. 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 Prime 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

If you need information in an accessible format or language, please contact Medica at **1 (800) 918-2143** (TTY: **711**) from 8 a.m.-8 p.m. CT, seven days a week.

5	PLEASE CAREFULLY READ THE FOLLOWING STATEMENTS

Check all that apply. By checking any of the statements below, you are representing that, to the best of your knowledge and belief, 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 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).
- ❍ 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).
- ❍ Permanent residence changed; moved from _____ / ____ or _____ on __ / __ / __ (date).
  County State Country
- ❍ 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).
- ❍ Live in a Long-Term Care Facility.
- ❍ Moving into or moved out of a Long-Term Care Facility on __ / __ / __ (date).
- ❍ Left a Program of All-Inclusive Care for the Elderly (PACE) 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

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

Please do not submit payment with your application.

You can pay your monthly plan premium by mail or Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security Check 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 or Railroad Retirement Board benefit check or be billed directly by Medicare. Do NOT pay the Part D-IRMAA extra amount to Medica.

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 the fifth business 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 are a member of a Medicare Advantage Plan (like an HMO or PPO), you may already have prescription drug coverage from your Medicare Advantage Plan that will meet your needs. By joining Medica Prime Solution, your membership in your Medicare Advantage Plan may end. This will affect both your doctor and hospital coverage as well as your prescription drug coverage. Read the information that your Medicare Advantage Plan sends you and if you have questions, contact your Medicare Advantage Plan.

If you currently have health coverage from an employer or union, joining Medica Prime Solution could affect your employer or union health benefits. If you have health coverage from an employer or union, joining Prime Solution and selecting the Medicare Prescription Drug benefit may change how your current coverage works. 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

By completing this enrollment application, I agree to the following:
Medica Prime Solution (Medica) is a Medicare health plan and I will need to keep my Medicare Part B. I can be in only one Medicare health plan at a time. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I know I may disenroll from this plan at any time by sending a written request to Medica or by calling 1-800-MEDICARE (1-800-633-4227) 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.

Once I enroll, I may leave this plan or make changes if an enrollment period is available, generally during the Annual Enrollment Period (Oct. 15 – Dec. 7), unless I qualify for certain special circumstances.

Medica Prime Solution serves a specific service area. If I move out of the area that Medica Prime Solution serves, I need to notify Medica so I can disenroll and find a plan in my new area. Once I am a member of Medica Prime Solution, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Medica when I receive it to know which rules I must follow in order to receive coverage with this Medicare health plan.

Beginning on the date Medica Prime Solution coverage starts, I must receive all of my health care from Medica-contracted providers to receive the highest level of benefits, with the exception of emergency or urgently needed services or for out-of-area renal dialysis. If I obtain routine services from non-network providers that are not authorized for coverage by Medica under the plan, I will be responsible for all Medicare deductibles and coinsurance, as well as any additional charges as prescribed by the Medicare program. I may also be liable for charges not covered by Medicare.

Medicare beneficiaries 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.

Release of Information:
By joining this Medicare health plan, I authorize Medica, its claims administrator, the Centers for Medicare and Medicaid Services (and its designee(s)), 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. I also acknowledge that Medica will release my information, including my prescription drug event data, to Medicare who may release it for research and other purposes which follow all applicable Federal statutes and regulations. 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 further understand that I have the right to revoke this authorization, at any time, by contacting Medica in writing. Medica conditions enrollment on this authorization and my revocation or failure to provide authorization may affect my enrollment. However, if I revoke this authorization, it will not affect any actions already taken by Medica prior to Medica's receipt of the revocation. Unless revoked, this authorization remains in effect until termination of coverage.

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

Medica®

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