**WISCONSIN RESIDENTS**

# Medica Prime Solution® (Cost) Plan

## 2023 Change Form — Standard, Thrift, Focus, or Total

### A PLEASE READ BEFORE COMPLETING YOUR APPLICATION

Use this form if you want to change from one Medica Prime Solution medical plan to another Medica Prime Solution medical plan. **This form cannot be used to enroll in Medica Prime Solution for the first time.**

If you have any questions concerning your application or if you need information in another language or format (like Braille or large print), please contact Medica at **1 (800) 918-2416** (TTY: **711**) from 8 a.m.-8 p.m. CT, seven days a week.

Return completed applications one of three ways:

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

### 1 PERSONAL INFORMATION

| Legal First Name | Middle Initial | Last Name |
|---|---|---|
| | | |

| Gender | Birthdate |
|---|---|
| ❍ Male ❍ Female | __ __ / __ __ / __ __ __ __<br>(M M / D D / Y Y Y Y) |
| Primary Telephone (*With area code)*<br>( ____ ) ____ - _____ | Medica Member Number *(required)* |

**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 | 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.

You must reside in one of the following counties: Ashland, Barron, Bayfield, Burnett, Chippewa, Douglas, Dunn, Eau Claire, Pierce, Polk, Sawyer, St. Croix, or Washburn.

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

**STANDARD**

Medica Prime Solution Standard has a Limited Change Enrollment Period. Enrollment in this plan is restricted to the following:

- Change from a Medica Cost medical plan to a Medica Prime Solution Standard medical only plan is available for effective dates of 1/1, 2/1, 3/1, or 4/1.

Medical Only Coverage:

❍ Standard: $0.00/month

**THRIFT, FOCUS, OR TOTAL**

Medical Only Coverage:

❍ Thrift: $40.00/month

❍ Focus: $87.00/month

❍ Total: $194.00/month

## 3 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.

**Please choose a payment method**:

❍ Continue my current payment method (if you do not make a new selection below, your current method will continue)

❍ Start monthly invoicing

❍ Start 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)<br>❍ Savings (attach a deposit slip) | |

❍ Start 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

| 4 | 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.

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)), 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. 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. **I understand that by changing my plan option, my benefits, premiums, and automatic payment will change.** 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®

**PO Box 9310, Minneapolis, MN 55440-9310**