Medica Prime Solution® Cost Plan

2014 Enrollment Application Form for Medica Prime Solution

Value, Basic or **Enhanced**

Medica Prime Solution® is a Medicare Cost product offered by Medica Insurance Company ("Medica"), an insurance company licensed by the states of Minnesota, North Dakota, South Dakota and Wisconsin.

Important Information:

- Please consult the Summary of Benefits for eligibility and more details on the plans available. You may choose the Medica Prime Solution **Value**, Medica Prime Solution **Basic** or Medica Prime Solution **Enhanced** plan. Remember, you must continue to pay your Medicare Part B premium.
- If you have any questions concerning your application or if you need information in another format, please contact Customer Service from 8 a.m. to 8 p.m. Central Time, seven days a week, at 952-992-2345 or 1-800-906-5432. TTY users, please call the National Relay Center at 1-800-855-2880.
- You can only be in one Medicare health plan at a time. By joining Medica Prime Solution, your membership in any other Medicare Advantage or Medicare Cost plan will end. This will affect both your doctor and hospital coverage as well as your prescription drug benefits.
- **If you currently have health coverage from an employer or union, joining Medica Prime Solution and selecting a Medica Part D Rider may affect your employer or union health benefits and 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.
- If you are assessed a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), 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.
- The Medica Prime Solution policies provide an anticipated loss ratio of 85%. This means that on average, no less than $85 of every $100 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. Missing or incomplete information may cause a delay in the effective date of your coverage. Use a black or blue pen and print firmly.

Return completed applications to:

Medica Medicare Solutions
PO Box 6300
Eau Claire, WI 54702-9713

OR

Fax to:

1-855-250-2166

MEDICA®

WHITE – Medica YELLOW – Applicant

2014 Medica Prime Solution® Enrollment Application Form

■ Section 1: Complete this section about yourself

(Please print your name exactly the way it appears on your Medicare card)

Legal First Name	M.I.	Last Name	Sex ❑ Male ❑ Female

Permanent Residence Address	City	State	ZIP	County
Mailing Address *(if different from above)*	City	State	ZIP	County

Home Telephone *(with area code)*	Alternate Telephone *(with area code)*	Birth Date __ __ / __ __ / __ __ __ __ (M M / D D / Y Y Y Y)

E-mail Address *(optional – by providing you agree that Medica may send you e-mails)*	What is your Preferred Language?

■ Section 2: Medicare information (Your enrollment form cannot be processed without this information)

Fill in these blanks to the right so they **MATCH** what appears on your red, white and blue Medicare card.

OR

Attach a copy of your Medicare card.

OR

Attach a copy of your Letter of Verification for Medicare eligibility from Social Security or the Railroad Retirement Board.

MEDICARE HEALTH INSURANCE

Name:_____

Medicare Claim Number: Sex:

_____ _____

Is Entitled To Effective Date

Hospital Insurance (Part A): _____

Medical Insurance (Part B): _____

■ Section 3: Effective date and plan selection

1. I am requesting an effective date for the first day of _____, 2014.
   (month)
2. Select a Medica Prime Solution Plan
   - ❑ Medica Prime Solution **Value**: $63.00 per month
   - ❑ Medica Prime Solution **Basic**: $79.00 per month
   - ❑ Medica Prime Solution **Enhanced**: $129.00 per month
3. Select Part D prescription drug coverage (choose one option below)
   - ❑ Add Part D **Option 1**: $21.70 per month
   - ❑ Add Part D **Option 2**: $62.50 per month
   - ❑ **I am not adding Part D coverage through Medica**
4. Select dental coverage (dental coverage is optional)
   - ❑ Add Medica **SeniorDental®**: $54.60

■ Section 4: Please answer these questions

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

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

   ESRD is kidney disease requiring dialysis. You cannot enroll in this plan if you have ESRD, unless A) you are enrolled in a Medica plan as a non-Medicare member and you developed ESRD while a Medica member; or B) you have had a successful kidney transplant and no longer require dialysis (please attach a note or records from your doctor showing you do not need dialysis or have had a successful kidney transplant).

   ❑ **YES** ❑ **NO**

2. What health plan coverage other than Original Medicare have you had within the last 60 days? (Check all that apply)

   ❑ I do not have a health plan
   ❑ Medicare Advantage (MA) plan*
   ❑ Medicare Cost plan*
   ❑ Medicare Supplement (Medigap)
   ❑ Employer/union
   ❑ Individual plan
   ❑ COBRA
   ❑ PACE
   ❑ Veterans Affairs benefits
   ❑ TRICARE
   ❑ State health care program
   ❑ High Risk Pool Plan

3. What prescription drug coverage have you had within the last 60 days? (Check all that apply)

   ❑ I do not have drug coverage
   ❑ Part of my health plan listed above
   ❑ Stand alone Prescription Drug Plan (PDP)
   ❑ State Pharmacy Assistance Program (SPAP)

* When joining Medica Prime Solution, you cannot keep your current Medicare Advantage or Cost plan coverage.

■ Section 5: Special enrollment checklist (Check all that apply)

Please read the following statements carefully and check the box of the statements that apply to you. By checking any of boxes 1 through 11 you are representing that, to the best of your knowledge and belief, you are eligible for a Special Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

❑ My current Medicare Advantage or Medicare Cost Plan is not renewing.

❑ I am leaving or recently left employer or union coverage on ___/___/____ *(date)*.

❑ My permanent residence has changed—moved from _____/_____ *(county/state)* on ___/___/____ *(date)*.

❑ I currently receive extra help paying for my Medicare prescription drug coverage.

❑ My extra help paying for my Medicare prescription drug coverage recently ended on ___/___/____ *(date)*.

❑ I belong to a pharmacy assistance program provided by my state.

❑ I involuntarily lost or will involuntarily lose my prescription drug coverage on ___/___/____ *(date)*.

❑ I currently live in a Long-Term Care Facility.

❑ I am moving into or recently moved out of a Long-Term Care Facility on ___/___/____ *(date)*.

❑ I recently left a Program of All-Inclusive Care for the Elderly (PACE) on ___/___/____ *(date)*.

❑ I recently lived outside of the United States and returned as a permanent resident on ___/___/____ *(date)*.

❑ None of these statements apply to me.

■ Section 6: Payment method (Please do not submit payment with your application)

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: ❑ **Checking** *(attach a voided check)* ❑ **Savings** *(attach a deposit slip)*	Financial Institution Name:

The "account holder" information below is required if you are not the account holder.

Account Holder Name:	Account Holder Telephone Number:
Account Holder Signature:	

❑ **Social Security or Railroad Retirement Board deduction**
You may have the monthly premium for both the Part D drug plan and Prime Solution plan (including any other riders) automatically deducted from your Social Security or Railroad Retirement Board (RRB) check. The deduction may take two or more months to begin after Social Security/RRB approves it. We will send you a paper invoice for those months before the deduction starts.

Note: If you qualify for extra help with your Medicare prescription drug costs, Medicare will pay all or some portion of your plan premium for this benefit. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare does not cover.

■ Section 7: Sign and date

APPLICANT

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this application means that I acknowledge, accept receipt of, and understand the meaning of this application, the statements of understanding on page 5 of this application, and the Medica Prime Solution Summary of Benefits. If signed by an authorized individual (as described above), this signature represents that, to the best of that individual's knowledge and belief: 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 _____ ___/___/____
Your Signature Today's Date

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

Name: _____ Address: _____

Telephone Number: _____ Relationship to Enrollee: _____

■ Agent use only

Murray Herstein _____ 245 _____
Agent Name (please print) ID Number

X _____ (612)991-3546 _____ ____/____/_____
Agent Signature Agent Telephone Agent's Receipt Date

■ Office use only

Affiliation Name _____

Affiliation ID _____

■ Statements of Understanding

By completing Section 7, 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 with each other as is necessary for treatment, payment and health care operations. I also authorize this information to be released to Medicare who may release it for research and other purposes which follow all applicable federal law. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by applicable privacy rules. 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 further understand and agree that:

1. Medica Prime Solution is a Medicare health plan. I will need to keep my Medicare Part B. I can only be in one Medicare health plan at a time and I can only be in one Medicare prescription drug plan at a time.
2. I may request to disenroll from Medica Prime Solution at any time by sending a written request to Medica or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
3. Medica Prime Solution serves a specific service area. It is my responsibility to tell Medica before I permanently move, leave the service area for more than **90 consecutive days**, or, if I have activated the Extended Absence Option, for more than **9 consecutive months**. I understand that my absence means that Medica Prime Solution may take action to disenroll me and return me to traditional Medicare coverage.
4. People with Medicare aren't usually covered under Medicare while outside of the country except for limited coverage in Canada and Mexico. Services authorized by Medica and other services contained in my Medica Prime Solution Evidence of Coverage document (also known as a member contract) will be covered.
5. Medica Prime Solution will send me written notification of the effective date of my enrollment.
6. Once I am a member of Medica Prime Solution, I have the right to appeal plan decisions about payment of coverage for services with which I disagree. I will read the Evidence of Coverage and Rider documents from Medica when I receive them to know which rules I must follow in order to receive coverage under Medica Prime Solution, a Medicare Cost plan. The premium and copayment amounts were stated to me, and may also be found in the Evidence of Coverage.
7. 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.
8. 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.
9. If I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Medica, he/she may be paid based on my enrollment in Medica Prime Solution.

The information on this 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.

Applicable to Minnesota Residents Only

Medica Insurance Company, 401 Carlson Parkway, Minnetonka, MN 55305
Telephone 952-992-2345 or 1-800-906-5432 (TTY: 1-800-855-2880 and ask for 1-800-906-5432)

NOTICE CONCERNING POLICYHOLDER RIGHTS IN AN INSOLVENCY UNDER THE MINNESOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION LAW

If the insurer that issued your life, annuity, or health insurance policy becomes impaired or insolvent, you are entitled to compensation for your policy from the assets of that insurer. The amount you recover will depend on the financial condition of the insurer.

In addition, residents of Minnesota who purchase life insurance, annuities, or health insurance from insurance companies authorized to do business in Minnesota are protected, **SUBJECT TO LIMITS AND EXCLUSIONS**, in the event the insurer becomes financially impaired or insolvent. This protection is provided by the Minnesota Life and Health Insurance Guaranty Association.

Minnesota Life and Health Insurance Guaranty Association
4760 White Bear Parkway, Suite 101
White Bear Lake, MN 55110
Telephone: 651-407-3149
Fax: 651-407-3150

The **maximum amount** the guaranty association will pay for all policies issued on one life by the same insurer **is limited to $500,000. Subject to this $500,000 limit,** the guaranty association will pay up to $500,000 in life insurance death benefits, $130,000 in net cash surrender and net cash withdrawal values for life insurance, $500,000 in health insurance benefits, including any net cash surrender and net cash withdrawal values, $250,000 in the present value of annuity benefits including net cash surrender and net cash withdrawal values, $410,000 in present value of annuity benefits for annuities which are part of a structured settlement or for annuities in regard to which periodic annuity benefits, for a period of not less than the annuitant's lifetime or for a period certain of not less than ten years, have begun to be paid on or before the date of impairment or insolvency, or if no coverage limit has been specified for a covered policy or benefit, the coverage limit shall be $500,000 in present value. Unallocated annuity contracts issued to retirement plans, other than defined benefit plans, established under section 401, 403(b), or 457 of the Internal Revenue Code of 1986, as amended through December 31, 1992, are covered up to $250,000 in net cash surrender and net cash withdrawal values, for Minnesota residents covered by the plan provided, however, that the association shall not be responsible for more than $10,000,000 in claims from all Minnesota residents covered by the plan. If total claims exceed $10,000,000, the $10,000,000 shall be prorated among all claimants. These are the maximum claim amounts. Coverage by the guaranty association is also subject to other substantial limitations and exclusions and requires continued residency in Minnesota. If your claim exceeds the guaranty association's limits, you may still recover a part or all of that amount from the proceeds of the liquidation of the insolvent insurer, if any exist. Funds to pay claims may not be immediately available. The guaranty association assesses insurers licensed to sell life and health insurance in Minnesota after the insolvency occurs. Claims are paid from this assessment.

THE COVERAGE PROVIDED BY THE GUARANTY ASSOCIATION IS NOT A SUBSTITUTE FOR USING CARE IN SELECTING INSURANCE COMPANIES THAT ARE WELL MANAGED AND FINANCIALLY STABLE. IN SELECTING AN INSURANCE COMPANY OR POLICY, YOU SHOULD NOT RELY ON COVERAGE BY THE GUARANTY ASSOCIATION.

THIS NOTICE IS REQUIRED BY MINNESOTA STATE LAW TO ADVISE POLICY HOLDERS OF LIFE, ANNUITY, OR HEALTH INSURANCE POLICIES OF THEIR RIGHTS IN THE EVENT THEIR INSURANCE CARRIER BECOMES FINANCIALLY INSOLVENT. THIS NOTICE IN NO WAY IMPLIES THAT THE COMPANY CURRENTLY HAS ANY TYPE OF FINANCIAL PROBLEMS. ALL LIFE, ANNUITY, AND HEALTH INSURANCE POLICIES ARE REQUIRED TO PROVIDE THIS NOTICE.

MEDICA®
PO Box 9310, Minneapolis, MN 55440-9310

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Medica Medicare Solutions® and Medica Prime Solution® are registered service marks of Medica Health Plans.

Medica is a Cost plan with a Medicare contract.

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