

Medica Prime Solution®

Medica Part D Rider Packages

Enrollment Application Form

This form is to be used by Medica Prime Solution members who are adding the Medica Part D Rider to their existing medical benefits. This form may not be used to enroll in Medica Prime Solution for the first time or to add or cancel other benefit riders.

Important Information

1. Please consult your Summary of Benefits for more details on the Medica Part D Rider Packages available. If you are enrolled in the Medica Prime Solution Value plan, you may choose the Modified Standard Rx option. If you are enrolled in the Medica Prime Solution Basic or Medica Prime Solution Enhanced plan, you may choose the Modified Standard Rx or Enhanced Rx option.
2. You can enroll in Medicare Prescription Drug coverage only at certain times of the year. If you are enrolling outside the annual enrollment period (November 15 – December 31), you also need to complete the Prescription Drug Enrollment Checklist. You may contact our Customer Service department if you would like assistance.
3. The premium for the Modified Standard Rx is \$26.70 per month and the Enhanced Rx is \$38.90 per month. This premium is added to your Medica Prime Solution Medical premium.
4. If you have any questions concerning your application, please contact Customer Service 8 a.m. to 8 p.m. CST, seven days a week at 952-992-2300 or 1-800-234-8755. TTY users may call 952-992-3650 or 1-800-234-8819.

To Obtain the Medica Part D Rider,

A. Please Provide Information About You (Please print clearly)

Legal First Name	M.I.	Last Name			Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Permanent Residence Address	City	State	Zip	County	
Mailing Address (if different from above)	City	State	Zip	County	
Home Phone (with area code)	Social Security Number (optional)		Member ID # (required)		Birth Date

B. Medica Part D Rider Options

PLEASE CHECK WHICH MEDICA PART D RIDER PACKAGE YOU WANT TO ENROLL IN:

- Modified Standard Rx: \$26.70 per month
- Enhanced Rx: \$38.90 per month (not available with Medica Prime Solution Value)

C. Please Read This Important Information

If you currently have prescription drug coverage from an employer or union, joining this Medica Prime Solution Part D drug plan 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 may help you.

D. If Desired, Please Select Your Additional Plan Premium Payment Option

You may have the monthly premium for both the Medica Part D Rider and your Medica Prime Solution plan (including any other riders for which you are enrolled) automatically deducted from your Social Security check. If you do choose this option, **all premiums must be deducted together**. If you don't choose this option, we will bill you each month, or you may elect to have your premium deducted from your bank account by the Automated Clearing House (ACH). Generally, you must stay with the option you choose for the rest of the year.

Note: If you qualify for extra help with your Medicare prescription drug coverage 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.

Please choose a payment method (do not submit payment with this enrollment form):

- Monthly Invoicing
- Monthly ACH (paperwork completed and attached)
- Social Security Deduction

E. Please Answer the Following Questions

1. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA Benefits or State Pharmaceutical Assistance Programs.

Do you or will you have other (non Part D) prescription drug coverage in addition to the Medica Part D Rider?

- Yes No

If "Yes," please list your other coverage and your identification (ID) number(s):

Name of other coverage

ID # for coverage

Group # for coverage

2. Are you a resident in a Long Term Care Facility, such as a nursing home? Yes No

If "Yes," please provide the following information:

Name of Institution

Address & Phone Number of Institution (number and street)

F. Please Read and Sign Below

By completing this enrollment form, I agree to the following: The Medica Prime Solution Part D coverage is a Medicare drug plan and is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare coverage. It is my responsibility to inform Medica of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare prescription drug plan at a time – if I am currently in a Medicare prescription drug plan, my enrollment in the Medica Part D Rider will end that enrollment. Enrollment in this plan is generally for the entire year. **I may leave this plan only at certain times of the year**, or under certain special circumstances, by sending a request to Medica or by calling 1-800-Medicare, 24 hours per day, 7 days per week. TTY users should call 1-877-486-2048.

Medica Prime Solution serves a specific service area and it is my responsibility to tell Medica before I permanently move or leave the service area for more than 90 consecutive days. Unless I have enacted the Extended Absence Option, my absence means that Medica must take action to disenroll me and return me to traditional Medicare coverage. I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage and Part D Rider documents from Medica when I receive them to know which rules I must follow in order to receive coverage with this Medicare drug plan.

Authorization: I authorize Medica to release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also authorize Medica to 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. I authorize the U.S. Department of Health and Human Services (or its designees) and any health care professional or entity, insurance company, employer, or other person to give Medica or any of its designees any and all records or information pertaining to medical history or services rendered to me. I understand that this information will be used for enrollment or eligibility for benefits. I understand that in certain circumstances Medica may disclose the information collected to third parties without authorization and that I have the right to see and correct my personal information in accordance with applicable law. I understand that Medica may disclose information to my agent of record for the purpose of assisting me with the administration of my account. I understand that I have the right to request restrictions on the use or disclosure of protected health information. Medica is not required to agree to any such restrictions, but if it does agree, Medica will abide by the terms of the restrictions. Any protected health information obtained under this authorization shall remain subject to Medica's privacy standards. I understand that I have the right to review the Privacy Notice before signing this form and to request a copy at any time. I also authorize the use of a Social Security Number (if provided) or a Medicare Claim Number for the purpose of identification. I have the right to revoke this authorization at any time by providing written notice to Medica. I understand that Medica conditions enrollment on this authorization and my revocation or failure to provide authorization may affect my enrollment. If I revoke the 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. The information provided on this enrollment form is accurate and complete. I understand and agree that any omissions or incorrect statements knowingly made by me on this enrollment form may invalidate my coverage.

APPLICANT	<p>I am requesting an effective date of _____ . I understand my effective date is assigned by Medica and I will receive written notification.</p> <p>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 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.</p>			
	<p>X</p> <p>Your Signature _____</p>			<p>Today's Date / /</p>
	<p>If you are the authorized representative, you must provide the following information:</p> <p>Name: _____ Address: _____</p> <p>Phone Number: _____ Relationship to Enrollee: _____</p>			
AGENT	<p>X _____ RICK PAVLISICH 101966 612-867-9564 / /</p> <p>Agent Signature Agent Name and ID # (Please Print) Agent Phone # Date</p>			
	<p>Please write legibly to ensure correct processing.</p>			
MEDICA USE	<p>Election Period:</p> <p><input type="checkbox"/> AEP <input type="checkbox"/> OEP <input type="checkbox"/> SEP <input type="checkbox"/> ICEP</p> <p>Proposed Eff. Date: _____</p> <p>Group #: _____ Cycle #: _____</p> <p>County Code: _____</p>			
		Initial Receipt Date	Control Receipt	Deemed Complete
<p>- 3 -</p>				

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