

## ► Enrollment Application Form

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, that holds a Medicare Competitive Medical Plan (CMP) contract with the Centers for Medicare and Medicaid Services (CMS). Medica Prime Solution is a member of the Medica Medicare Solutions® family of products and services.

### ▼ Important Information

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1. Please consult the Summaries 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.
2. 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 952-992-2345 or 1-800-906-5432. TTY users may call 952-992-3650 or 1-800-234-8819.
3. **If you are a member of a Medicare Advantage Plan** (like an HMO or PPO) **or a Medicare Cost Plan**, you may already have a prescription drug benefit that will meet your needs. By joining Medica Prime Solution, your membership in your Medicare Advantage or Medicare Cost plan may end. This will affect both your doctor and hospital coverage as well as your prescription drug benefits. Read the information that your Medicare plan sends you and if you have questions, contact your Medicare plan.
4. **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.
5. If you are enrolling for a Medica Part D Rider outside of the annual enrollment period between November 15 and December 31, please complete the Prescription Drug Enrollment Checklist. You may contact our Customer Service department if you would like assistance.
6. The Medica Prime Solution policy provides an anticipated loss ratio of 88%. This means that on average, no less than \$88 of every \$100 in premium will be returned as benefits over the life of the policy.
7. 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/blue pen and print firmly.

Thank you for your interest in Medica Prime Solution.

H2450\_1327 (09-2007)  
MN-PRI-AP08-100-01  
WI-PRI-AP08-100-01

# Medica Prime Solution® Enrollment Application Form

## Section One: 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 <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)	Birth Date (___/___/____) (M M / D D / Y Y Y Y)		What is your Preferred Language?	


### I am applying for (check options):

- |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> <b>Medica Prime Solution – Value \$35.00 per month</b><br><input type="checkbox"/> with optional Medica Part D Rider<br>Modified Standard Rx \$26.70 per month<br><br><input type="checkbox"/> <b>Medica Prime Solution – Basic \$62.00 per month</b><br><input type="checkbox"/> with optional Medica Part D Rider<br>Modified Standard Rx \$26.70 per month<br><input type="checkbox"/> with optional Medica Part D Rider<br>Enhanced Rx \$38.90 per month | <input type="checkbox"/> <b>Medica Prime Solution – Enhanced \$112.00 per month</b><br><input type="checkbox"/> with optional Medica Part D Rider<br>Modified Standard Rx \$26.70 per month<br><input type="checkbox"/> with optional Medica Part D Rider<br>Enhanced Rx \$38.90 per month<br><input type="checkbox"/> with optional Wisconsin Rider \$20.50 per month<br>You must also complete the Wisconsin Rider Enrollment form. |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

## Section Two: Medicare information (Your enrollment form cannot be processed without this information)

We must verify your Medicare eligibility.  
Please select one of the following options:

- 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 the Social Security Administration or Railroad Retirement Board.

	
MEDICARE	HEALTH INSURANCE
SAMPLE ONLY	
Name: _____	
Medicare Claim Number: _____	Sex: _____
Is Entitled To _____	Effective Date _____
___ Hospital Insurance (Part A): _____	
___ Medical Insurance (Part B): _____	

## Section Three: Payment method (Please do not submit payment with application)

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:

- Monthly Invoicing       Monthly ACH (paperwork completed and attached)  
 Social Security Deduction: Only available if Medica Part D Rider is elected.

**Section Four: Please answer these questions. (This information is NOT used for health screening)**

1. Do you have End-Stage Renal Disease (ESRD)? .....  YES  NO  
You cannot enroll in this plan if you have ESRD, unless: A) you are already 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).
2. Do you have health coverage through your or your spouse's current or former employer? .....  YES  NO  
If YES, please provide the following information:  
Employer Name \_\_\_\_\_ Employer Address \_\_\_\_\_  
Policyholder Name \_\_\_\_\_ Policy Number \_\_\_\_\_
3. Do you have another Medicare policy or certificate in force (including a Medicare supplement, Cost Plan or a Medicare Advantage policy)? .....  YES  NO  
If YES, please list name of the plan \_\_\_\_\_  
If YES, you may need to send written cancellation of your membership to your current plan. You should not cancel your current plan until you have received confirmation of the effective date of your Medica Prime Solution, Medicare Cost plan.
4. Are you enrolled in your State Medicaid program? .....  YES  NO  
If YES, please provide your Medicaid number \_\_\_\_\_
5. Only answer this question if you have selected a Medica Part D Rider.  
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 \_\_\_\_\_
6. 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 and Phone Number of Institution (number and street) \_\_\_\_\_

**Section Five: Statements of Understanding (Please read and sign below)**

*I hereby authorize* the Centers for Medicare and Medicaid Services (CMS) to furnish information to Medica affirming my entitlement to Hospital Insurance Benefits (Part A) and enrollment for Supplementary Medical Insurance Benefits (Part B) under Title XVIII of the Social Security Act. I authorize Medica or any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services or intermediaries or carriers any information needed to administer Title XVIII of the Social Security Act.

*I understand* that Medica Prime Solution is a Medicare Health plan and I will need to keep my Medicare Part B. I can only be in one Medicare Health plan at a time. 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 Medica Prime Solution with the Part D Rider option 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.

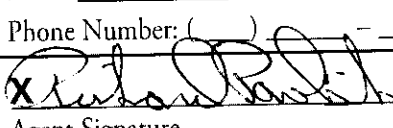
*I understand* that Medica Prime Solution serves a specific service area and it is my responsibility to tell Medica before I permanently move or leave the service area **for more than 90 consecutive days**. Unless I have enacted the Extended Absence Option, my absence means that Medica must take action to disenroll me and return me to traditional Medicare coverage. 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 and Rider documents from Medica when I receive them to know which rules I must follow in order to receive coverage with this Medicare Cost plan.

**Section Five: Statements of Understanding (continued)**

*I understand* that, beginning with my effective date and while in the Medica Prime Solution service area, 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. I understand that only services authorized by Medica and other services covered in my Medica Prime Solution Evidence of Coverage (policy) are covered. I also understand that without authorization from Medica, certain services may not be covered by either Medicare or Medica Prime Solution.

*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, 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 broker 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 application is accurate and complete. I understand and agree that any omissions or incorrect statements knowingly made by me on this application may invalidate my coverage.

<b>APPLICANT</b>	<p><b>I am requesting an effective date of</b> _____ . 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 acknowledge, accept receipt of, and understand the meaning of this Application, the above Statements of Understanding, and the Summary of Benefits. 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><b>X</b></p> <p>Your Signature _____</p> <p style="text-align:right;">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>			
<b>AGENT</b>	<p><b>X</b>  <b>Rick Pavlisich 101966</b> <b>612-867-9524</b></p> <p>Agent Signature Agent Name and ID # (Please Print) Agent Phone #</p>			<p>____ / ____ / ____</p> <p>Date</p>
	<p><b>Please write legibly to ensure correct processing.</b></p>			
<b>MEDICA USE</b>	<p><b>Election Period:</b></p> <p><input type="checkbox"/> AEP   <input type="checkbox"/> OEP   <input type="checkbox"/> SEP   <input checked="" type="checkbox"/> ICEP</p> <p>Proposed Eff. Date: _____</p> <p>Group #: _____ Cycle #: _____</p> <p>County Code: _____</p>			
		<p>Initial Receipt Date</p>	<p>Control Receipt</p>	<p>Deemed Complete</p>
				<p>Data Entry Date</p>

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**Applicable to Minnesota Residents Only**

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Medica Insurance Company, 401 Carlson Parkway, Minnetonka, MN 55305  
Telephone 952-992-2345 or 1-800-906-5432 (TTY: 952-992-3650 or 1-800-234-8819)

**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 \$300,000. Subject to this \$300,000 limit**, the guaranty association will pay up to \$300,000 in life insurance death benefits, \$100,000 in net cash surrender and net cash withdrawal values for life insurance, \$300,000 in health insurance benefits, including any net cash surrender and net cash withdrawal values, \$100,000 in annuity net cash surrender and net cash withdrawal values, \$300,000 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 \$300,000 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 \$100,000 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 \$7,500,000 in claims from all Minnesota residents covered by the plan. If total claims exceed \$7,500,000, the \$7,500,000 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 Prime Solution® and Medica Medicare Solutions® are registered service marks of Medica Health Plans.