

PLEASE TYPE or PRINT CLEARLY
USING BLUE OR BLACK INK.

A. APPLICANT INFORMATION

1) Applicant's name (<i>Last, First, Middle</i>)		2) Marital status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated			
3) If applicant is a minor child, please list parent(s) or legal guardian(s)					
4) Applicant's home address		<i>Street</i>	<i>City</i>	<i>State</i>	<i>ZIP</i>
5) Billing address (<i>if different from #4</i>)		<i>Street</i>	<i>City</i>	<i>State</i>	<i>ZIP</i>
6) E-mail address		7) Home telephone no. ()		8) Cellular telephone no. ()	
9) Are you a permanent resident of Minnesota? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," please explain:					
10) Occupation			Company name		
Self employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Work telephone no. ()		Hours worked per week _____ <input type="checkbox"/> Full time <input type="checkbox"/> Part time		Covered by Worker's Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No
Duties	11) Social Security Number		12) Birth date (<i>mo/day/yr</i>)		13) State of birth
	14) Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	15) Height ft. in.		16) Present weight lbs.	17) Weight one year ago lbs.
18) Reason for application (<i>check one</i>): <input type="checkbox"/> I am a new applicant presently not covered under a Medica policy. <input type="checkbox"/> I presently have Medica coverage. I am covered under I.D. number: _____					

B. ENROLLEE INFORMATION

If applicable, list the second person for whom application is being made:

1) Enrollee's name (<i>Last, First, Middle</i>)		2) Social Security Number			
3) Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		4) Birth date (<i>mo/day/yr</i>)		5) Relationship to applicant	
6) Height ft. in.		7) Present weight lbs.		8) Weight one year ago lbs.	

C. BENEFIT SELECTION

1) Select your plan's deductible level:

- 100% Plan
- \$4,000 Individual Coverage / \$6,000 Two-Person Coverage
- \$6,500 Individual Coverage / \$7,500 Two-Person Coverage
- \$9,000 Individual Coverage / \$9,000 Two-Person Coverage

2) Select your office visit copayment option:

- \$20 office visit copayment
- \$40 office visit copayment
- \$60 office visit copayment

Applicant's Name: _____

D. PAYMENT AND EFFECTIVE DATE SELECTION

1) Initial payment mode (*check one*)

- Check
- Credit Card

Amount paid with this application \$.

(Please make your check payable to Medica. Include the Credit Card Form if applicable.)

2) Ongoing payment mode (*check one*)

- Check
- Automatic Payment

(Include the ACH Authorization Form if applicable.)

3) **Effective Date:** Initial payment or payment information for this policy must be submitted with this application.

We cannot process your application if you fail to answer all questions completely or if you fail to submit your initial payment. I understand that, if approved by the last day of the month, coverage will be effective the first day of the following month. If possible, I would like my coverage to begin on the first of the month of _____, provided this date is not more than 60 days beyond the signature date of this application.

E. OTHER INSURANCE INFORMATION

1) Does any person named on this application currently have **any** health insurance coverage? Yes No

2) Has any person named on this application ever been a member of Medica? Yes No

3) Has any person named on this application had any health insurance coverage within the past 63 days? Yes No

If "Yes" to any question, you must provide your health coverage history for the past 24 months and complete the insurance information below.

	Insurance company name	Type of coverage	Effective date of coverage	Termination date of coverage
1		<input type="checkbox"/> Individual coverage <input type="checkbox"/> Group coverage <input type="checkbox"/> COBRA		
	Reason for termination of health care coverage:			
2		<input type="checkbox"/> Individual coverage <input type="checkbox"/> Group coverage <input type="checkbox"/> COBRA		
	Reason for termination of health care coverage:			

4) Will this coverage replace or change any existing health insurance? Yes No

If "Yes," please explain why: _____

5) Is any person named on this application covered by Medicare Part A and/or Part B? Yes No

6) Has any person named on this application applied for a Medica Individual plan in the past? Yes No

If "Yes," when? Month Year

Under what primary applicant name? _____

F. YOUR HEALTH INFORMATION

Answer every question by checking a Yes or No box. For each question answered "Yes," please complete Section F7.

SECTION F1: Has any person named on this application ever been diagnosed with, treated for, or consulted with a physician or practitioner for:

- | | Yes | No |
|---|--------------------------|--------------------------|
| a. Heart attack, coronary artery disease, heart bypass surgery, angioplasty, heart valve replacement or congestive heart failure? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Stroke, aneurysm, carotid artery blockage, blood clots, embolism or multiple sclerosis? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Emphysema, chronic obstructive pulmonary disease (COPD) or pulmonary fibrosis? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Hepatitis*, cirrhosis of the liver, pancreatitis, Crohn's disease or ulcerative colitis? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Diabetes? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Cancer? | <input type="checkbox"/> | <input type="checkbox"/> |
| g. HIV* positive, AIDS* or lupus? | <input type="checkbox"/> | <input type="checkbox"/> |

SECTION F2: Within the past five years, has any person named on this application been diagnosed with, or treated for, or consulted with a physician or practitioner for:

- | | | |
|--|--------------------------|--------------------------|
| a. Heart disorders, including but not limited to chest pain, heart murmur, mitral valve prolapse, angina, high blood pressure or cardiovascular disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Circulatory or vascular disorders, including but not limited to peripheral vascular disease, varicose veins, varicose ulcer, blockage of arteries or other vascular or circulatory disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Respiratory disorders, including but not limited to shortness of breath, tuberculosis, asthma, allergies, hay fever, sleep apnea, pneumonia, lung or respiratory disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Nervous system disorders, including but not limited to paralysis, epilepsy, fainting, dizziness, seizures, headaches, migraines, or any other disease or disorder of the brain or nervous system? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Digestive disorders, including but not limited to stomach or duodenal ulcer, other ulcer, hernia, gastroesophageal reflux disease (GERD), colitis, chronic diarrhea, jaundice, or any disorder of the liver, gallbladder, stomach, intestine, or rectum? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Urinary tract disorders, including but not limited to kidney, bladder, kidney and bladder stones, protein or blood in the urine, infection or other disorder(s) of the kidney(s), bladder, ureter(s) urethra, or prostate? | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Musculoskeletal disorders, including but not limited to arthritis, or any disorder of the joints, muscles or bones, any knee, neck, back or spinal trouble, neuritis, sciatica, spinal curvature to include kyphosis and lordosis, fibromyalgia, gout, carpal tunnel syndrome, TMJ or amputation? | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Reproductive system disorders, including but not limited to any disease or disorder of the breast or reproductive organs (male and female), complication of breast implants, infertility, abnormal menstrual periods, endometriosis, or sexually transmitted disease? . . . | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Metabolic or endocrine disorders, including but not limited to sugar intolerance, albumin, blood or sugar in the urine, any disorder of metabolism or endocrine system? | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Eating disorders, including but not limited to anorexia, bulimia, unexplained weight loss or fever, obesity or other related disorders? . . | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Tumor, cysts, neoplasm or growths of any kind? | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Immune system disorders, including but not limited to collagen disease, scleroderma, rheumatoid arthritis or any other connective tissue disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| m. Blood disorders, including but not limited to anemia, hemophilia, hemochromatosis, leukemia or any other disease or disorder of the blood? | <input type="checkbox"/> | <input type="checkbox"/> |
| n. Any disease of the eyes, ears, nose, throat, tonsils, or sinuses? | <input type="checkbox"/> | <input type="checkbox"/> |
| o. Mental, emotional or nervous disorders, including but not limited to hyperactivity, attention deficit, anxiety, depression or personality disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| p. Glandular disorders, including but not limited to Addison disease, Cushing disease, goiter, lymph gland enlargement or any disease or disorder of the adrenal gland, thyroid gland, pituitary, pancreas, or lymph system? | <input type="checkbox"/> | <input type="checkbox"/> |
| q. Congenital birth or developmental disorders, including but not limited to cleft palate, club foot, congenital heart defects, chromosomal abnormalities, physical or cognitive delays or autism? | <input type="checkbox"/> | <input type="checkbox"/> |
| r. Skin disorders, acne, psoriasis, warts, lesions or any other disease or disorder of the skin? | <input type="checkbox"/> | <input type="checkbox"/> |
| s. General fatigue, malaise, mononucleosis, Chronic Fatigue Syndrome or Epstein-Barr Syndrome? | <input type="checkbox"/> | <input type="checkbox"/> |

SECTION F3: Within the past five years, has any person named on this application:

- | | | |
|---|--------------------------|--------------------------|
| a. Been evaluated for, treated for, or joined any organization for alcoholism/chemical dependency (you are not required to disclose the name of the organization); consumed alcohol to excess or used any controlled drug not prescribed by a doctor or exceeded prescription usage of any drug without physician approval? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Been convicted for or had a driver's license suspended for DWI/DUI or been convicted for any alcohol or drug-related moving violation? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Been advised by a medical professional to modify or restrict eating or drinking habits for health purposes? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Been hospitalized? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Been advised by a medical professional to have surgery, treatment or testing, not yet performed? | <input type="checkbox"/> | <input type="checkbox"/> |

Continues next page >

* See page 2 for exceptions.

F. YOUR HEALTH INFORMATION continued

- | | | |
|--|--------------------------|--------------------------|
| | Yes | No |
| f. Participated in organized racing, including but not limited to automobile, motorcycle, or power boat racing or any of the following activities: skydiving, ultralight flying, scuba diving, hang gliding, rodeo participation, rock or mountain climbing? | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Had an electrocardiogram, MRI, CT scan, echocardiogram, laboratory or diagnostic test or X-ray (other than dental)? | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Been declined coverage, charged an increased rate, or had benefits excluded from coverage for any health care or life insurance coverage? | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Had any medical treatment, or diagnosed or treated health impairment not already noted in this enrollment form? | <input type="checkbox"/> | <input type="checkbox"/> |

SECTION F4: Is any person or has any person named on this application:

- | | | |
|---|--------------------------|--------------------------|
| a. An expectant father or expectant mother or anticipating the adoption of a child? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Expecting to become a parent through the use of assisted reproductive technologies such as infertility drugs or in-vitro fertilization? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Had any fixation/prosthetic devices, including but not limited to, plates, screws, pins, implants, shunts, pacemakers, or valve replacement? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Currently disabled, hospitalized, on medical leave or receiving disability or workers' compensation benefits? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Used tobacco products during the 12–36 months immediately preceding the date of this application? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Within the last six months, been seen by a health professional for any medical treatment? | <input type="checkbox"/> | <input type="checkbox"/> |

SECTION F5: Please list the date of last physical exam for all persons named on this application. Include blood pressure and cholesterol results. If female, please also list date of last Pap smear and result.

	Exam results	Physician name and complete address
1 Type of exam:		
Date of exam:		
2 Pap smear exam (if female)		
Date of exam:		

SECTION F6: Please list all medications taken for any persons named on this application in the past 12 months. Add an additional page if you need more space.

	Condition treated	Currently taking?
1 Drug name:		<input type="checkbox"/> Yes: Quantity (how many taken each day): <input type="checkbox"/> No: Date (mo/yr) stopped:
Dosage: mg/ml		
2 Drug name:		<input type="checkbox"/> Yes: Quantity (how many taken each day): <input type="checkbox"/> No: Date (mo/yr) stopped:
Dosage: mg/ml		
3 Drug name:		<input type="checkbox"/> Yes: Quantity (how many taken each day): <input type="checkbox"/> No: Date (mo/yr) stopped:
Dosage: mg/ml		

SECTION F7: If you have answered “Yes” to any questions in Sections F1 through F4, please complete this section. Give complete details. Add an additional page if you need more space.

	Diagnosis, treatment and results	Physician name and complete address
1 Question section & letter:		
Date of onset:		
Days in hospital:		
Date of complete recovery:		
2 Question section & letter:		
Date of onset:		
Days in hospital:		
Date of complete recovery:		

Applicant's Name: _____

G. AUTHORIZATION & REPRESENTATION – Read this section, then sign and date the application.

TO BE SIGNED BY APPLICANT:

I have reviewed the above statements/questions and the corresponding answers and represent them to be true and complete. I understand that this application form and any amendments will be the basis for my policy with Medica. Benefits under the policy, if approved, will be based upon the selection made in Section B, unless Medica has offered, and I have accepted, an alternative plan. I understand that if I, or any person named on this application do(es) not qualify for the coverage selected, Medica may offer an alternative plan. Medica will not rescind coverage that has been in effect for two (2) or more years UNLESS I knowingly made a misstatement on this application form.

I understand and agree that my policy, if approved, will be issued solely as an individual policy. The policy is not offered pursuant to and does not comply with state or federal group health plan laws. I understand and agree that any attempt to use the individual policy in a manner that results in it being considered a group health plan under state or federal law is strictly prohibited.

If there is a change in my (or my enrollee's) health condition between the date of this application and my effective date of coverage, I agree to notify Medica immediately. This new information may be used in determination and/or reversal of my acceptance. If I do not notify Medica of any change in my (or my enrollee's) health condition prior to my effective date of coverage, my policy may be rescinded.

On behalf of myself and anyone enrolled on or added to this application ("Us"), I authorize any hospital, clinic, institution, physician, insurance company, MIB, Inc. ("MIB"), or other organization, institution or person to give Medica or any of its designees any and all records or information pertaining to medical history or services rendered to me including, but not limited to, information relating to any medical records or medical insurance claims, consultations or treatments; outpatient or inpatient hospital services; prescription information and lab work. I understand that this information will be used for underwriting, risk rating, enrollment or eligibility for benefits. I understand that in certain circumstances Medica may disclose the information collected to third parties without authorization, and that the information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality, and that I have the right to see and correct my personal information in accordance with applicable law. I understand that I have the right to review Medica's Privacy Notice before signing this form and to request a copy at any time. This authorization does not extend to a release concerning the performance of, or results of, a test to determine the presence of the HIV antibody or other blood borne pathogen as described on page 2 of this enrollment form. I also authorize the use of a Social Security Number for the purpose of identification. The information provided on this application is accurate and complete. I understand and agree that any omissions or incorrect statements knowingly made by Us on this application may invalidate my or my enrollee's coverage. I understand that I may revoke this authorization by notifying Medica in writing. If I revoke the authorization, it will not affect any actions already taken by Medica prior to Medica's receipt of the revocation. If I refuse to sign this authorization, it will affect my and my enrollee's eligibility and enrollment for benefits. Unless revoked, this authorization will remain in effect until termination of coverage. Information used or disclosed pursuant to this authorization will remain subject to Medica's privacy standards. A photographic copy of this authorization shall be as valid as the original. I understand if I am approved for coverage, my policy will not cover preexisting conditions during the first 18 months following my enrollment date. However, if I have maintained continuous health care coverage, the preexisting condition limitation applies during the first 12 months following the enrollment, and will be reduced by the aggregate of certain periods of qualifying coverage applicable to me as of the enrollment date. I authorize Medica to disclose my protected health information to the Guarantor identified below if I am under age 18 and if such information is the basis for Medica's denial of coverage.

As an enrollee named on this application, I authorize Medica to disclose my protected health information to the Applicant if such information is the basis for Medica's denial of coverage.

I know that my application contains personal information, including my health care information. By checking "Yes" in the space provided, I will be releasing my application to both Medica and my broker of record, who will have access to my personal information. By checking "No" in the space provided, I will be releasing my application only to Medica. My broker of record will not receive my application or have access to my personal information. My choice will not affect my eligibility for the policy I am applying for. Yes No

X _____
Signature of Applicant Date

X _____
Signature of Enrollee Date
(If proposed to be insured)

X _____
Signature of Guarantor, Parent or Legal Guardian Date
(Please complete if the Applicant is under age 18)

A person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

H. FOR AGENT USE ONLY

Application was completed by Applicant (Parent or Legal Guardian if applicant is under age 18) Agent. I certify that I have reviewed this application. If application was completed by agent, agent certifies that he/she personally completed this application, that each question was asked separately, that the answers recorded in this application are complete and accurate as given. **Please write legibly for this to be processed.**

X _____ () _____
Signature of Agent Date Print Agent's Name & Number Agent's Telephone Number

I. FOR OFFICE USE ONLY

Date Received	Policy Effective Date	Plan Code	PE Mo.	Reviewed By:	Payment ID	Amount
				Date: A D		