

# Enrollment Application Form for Medica Prime Solution®

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 and South Dakota, 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.

## Enrollment Application Instructions

Please read before completing your application.

### You are eligible to join Medica Prime Solution if:

- You are enrolled in the Federal Medicare program for Part A (Hospital Insurance) and for Part B (Medical Insurance) or in Medicare Part B only. If you have Medicare Part B only, you only have coverage for Medicare Part B services. You do not have coverage for hospital, skilled nursing facilities and related services covered by Medicare Part A.
- You reside in the service area. (A list of counties within the service area is listed in the enclosed Summary of Benefits.)
- You do not have End Stage Renal Disease (ESRD), unless 1) you are already enrolled in a Medica plan as a non-Medicare member and you developed ESRD while a Medica member; or 2) you have had a successful kidney transplant and no longer require dialysis. Please attach a note or records from your doctor showing you no longer need dialysis or have had a successful kidney transplant.

- You are not currently participating in the Medicare hospice program for the terminally ill.

### To enroll, please make sure you have completed and forwarded all necessary information to Medica.

1. 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.
2. If you and your spouse wish to apply for Medica Prime Solution, please complete separate applications.
3. You must provide the information requested in Section Two so that we can verify your Medicare eligibility.
4. If this application is signed by someone other than the applicant, the application must include a copy of one of four legal documents proving that the person signing the application is the applicant’s authorized, legal representative:
  - 1) a Durable Power of Attorney;
  - 2) a Durable Power of Attorney for Health Care;
  - 3) a court order granting legal Guardianship; or
  - 4) a court order granting legal Conservatorship.

## Other Important Information

- 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.
- If you have any questions concerning your application, please contact our offices Monday – Thursday 8 a.m. – 5 p.m. or Friday 9 a.m. – 5 p.m., at 952-992-2345, 1-800-906-5432, or the TTY phone number for the hearing impaired at 952-992-3650 or 1-800-234-8819 for further instructions.
- Your proposed effective date is assigned by Medica. Applications must be signed, dated and received by Medica by the last business day of the month in order to be effective the first day of the month following receipt of your completed application. (Example – an application received between June 1 and June 30 will be effective July 1 of the same year.)
- This application is subject to approval from the Centers for Medicare and Medicaid Services (CMS). If your enrollment is not accepted by CMS, we will notify you immediately.
- **Remember, you must continue paying your Part B Medicare premium (this premium is usually deducted from your Social Security check).**
- To disenroll from this plan, send a written request to Medica, the Social Security Office, or the Railroad Retirement Board, or by calling 1-800-MEDICARE (TTY: 1-877-486-2048 for the hearing impaired or speech impaired). Until the effective date of disenrollment, you must receive health care from Medica-contracted providers to receive the highest level of benefits.
- As a member of Medica Prime Solution, you have the right to **ask about the plan’s decision** about payment or services if you disagree.
- Medica coordinates benefits with Medicare for services received from Medica-contracted hospitals and skilled nursing facilities. You must present both your Medicare ID and your Medica Prime Solution ID cards at the time of service. You also have the option of using providers not contracted with Medica by presenting only your Medicare card. However, unless you meet the criteria established by Medica under the Extended Absence Option, you are responsible for paying any applicable Medicare deductible, coinsurance, and ineligible expenses, as well as filing the necessary claims paperwork with Medicare.

# Medica Prime Solution® Enrollment Application

## 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	Birth Date	What is your Preferred Language?	

I am applying for (check options):

**Medica Prime Solution – Basic \$96**

with optional Plus Rider I \$16 (Minnesota only) **or**

with optional Plus Rider II \$5 (North and South Dakota only)

with optional Medica Part D Rider – Enclose Rider application

↔  
**OR**

**Medica Prime Solution – Enhanced \$115**

with optional Plus Rider I \$16 (Minnesota only) **or**

with optional Plus Rider II \$5 (North and South Dakota only)

with optional Medica Part D Rider – Enclose Rider application

## Section Two: Medicare 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 Medicare card; **OR**
- Attach a copy of your Medicare card; **OR**
- Attach your Letter of Verification for Medicare eligibility from the Social Security Administration or Railroad Retirement Board.

**Your enrollment form cannot be processed without this information.**

### MEDICARE HEALTH INSURANCE

Social Security Act

Name of Beneficiary: \_\_\_\_\_

Medicare Claim Number: \_\_\_\_\_ Sex: \_\_\_\_\_

-----

Is Entitled To \_\_\_\_\_ Effective Date \_\_\_\_\_

\_\_\_Hospital Insurance (Part A): \_\_\_\_\_

\_\_\_Medical Insurance (Part B): \_\_\_\_\_

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

1. Are you currently participating in the Medicare hospice program for the terminally ill? .....  **YES**  **NO**  
If YES, you are **NOT** eligible to enroll in Medica Prime Solution.
2. Do you have End Stage Renal Disease (ESRD)? .....  **YES**  **NO**  
ESRD is permanent kidney failure and requires regular kidney dialysis or a transplant to sustain life.  
(**Note:** You cannot enroll in this plan if you have ESRD, unless 1) you are already enrolled in a Medica plan as a non-Medicare member and you developed ESRD while a Medica member; or 2) you have had a successful kidney transplant and no longer require dialysis. Please attach a note or records from your doctor showing you no longer need dialysis or have had a successful kidney transplant.)
- 3a. Do you have another Medicare policy or certificate in force (including a Medicare supplement, Cost Plan or a Medicare Advantage policy)? .....  **YES**  **NO**
- 3b. If YES, please list name of the plan \_\_\_\_\_
- 3c. 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. Do you have any other health insurance coverage on your own or through your spouse that provides benefits that this plan would duplicate? .....  **YES**  **NO**

## Section Four: Payment Method (Please do not submit payment with application)

- Monthly Invoicing       Monthly ACH (paperwork completed and attached)

WHITE – Medica

YELLOW – Agent

PINK – Applicant

## Section Five: Statements of Understanding

**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 by enrolling in Medica Prime Solution, I will automatically be disenrolled from any other Medicare Advantage or Medicare Cost plan of which I am currently a member.

**I understand** that since I can be a member of only one Medicare Advantage or Medicare Cost plan at a time, **I cannot enroll in more than one Medicare Advantage or Medicare Cost plan** with the same effective date of coverage. If I do this, both enrollments will be cancelled and I will have to reapply for coverage.

**I understand** that 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 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** any health care professional or entity 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 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 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>Please read the information on this Enrollment Application and Statements of Understanding and sign and date the application below.</b> I acknowledge, accept receipt of, and understand the meaning of this Application, the above Statements of Understanding, and the Summary of Benefits.</p> <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. Unless notified otherwise, I should begin receiving all my medical care from Medica-contracted providers as of that date.</p>			
	<p><b>X</b> _____ / /</p>			<p>Today's Date</p>
	<p>Applicant or Legal Representative Signature</p> <p>If signed by Representative, attach copy of: <input type="checkbox"/> Durable Power of Attorney for Health Care (DPAHC)  <input type="checkbox"/> Durable Power of Attorney <input type="checkbox"/> Legal Guardianship <input type="checkbox"/> Legal Conservatorship</p>			

<b>AGENT</b>	<p><b>X</b> _____ / /</p>			<p>Date</p>
	<p>Agent Signature</p> <p>Agent Name (Please Print) <u>Murray Herstein</u></p> <p>Agent ID # <u>245</u> Agent Phone # <u>612-991-3546</u></p>			
	<p><b>Please write legibly or may not be processed</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 type="checkbox"/> ICEP</p> <p>Proposed Eff. Date: _____</p> <p>Group #: _____ Cycle #: _____</p> <p>County Code: _____ <input type="checkbox"/> POA</p>	<p>Initial Receipt Date</p>	<p>Control Receipt</p>	<p>Deemed Complete</p>	<p>Data Entry Date</p>
	<p> </p>				
	<p> </p>				

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

---

**Applicable to Minnesota Residents Only**

**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 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®**

© 2005 Medica. Medica® is a registered service mark of Medica Health Plans. "Medica" refers to the family of health plan businesses that includes Medica Health Plans, Medica Health Plans of Wisconsin, Medica Insurance Company, and Medica Self-Insured.

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