

**ENROLLMENT FORM PLEASE TYPE OR PRINT**

MEMBER INFORMATION				
First Name	M.I.	Last Name		
Address	Street	City	State	Zip
Telephone Number	Social Security Number <i>(optional)</i>		Medicare Claim Number <i>(required)</i>	
Which Medica health plan have you applied for or are currently enrolled in? <input type="checkbox"/> Medica Prime Solution® Basic <input type="checkbox"/> Medica Select Solution® Basic <input type="checkbox"/> Medica Prime Solution® Enhanced <input type="checkbox"/> Medica Select Solution® Extended Basic				
If you are a current member, what is your Medica member ID number? _____				

<b>APPLICANT</b>	<p><b>AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION:</b></p> <p>I authorize any health care professional or entity to give Medica and/or insurer of any of their designees or affiliates, any and all records or information pertaining to medical history or services rendered to me for any administrative purposes, including evaluation of an application or claim, and for any analytical or research purposes. 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 purposes 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. The information provided on this application is accurate and complete. Unless revoked, this authorization remains in effect until termination of coverage. I understand and agree that any omissions or incorrect statements knowingly made by me on this application may invalidate my coverage. 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 Medicare.</p>			
	<p><b>X</b></p> <p>Your Signature _____ Today's Date _____</p> <p>If you are the authorized representative, you must provide the following information:                  Name: _____ Address: _____                  Telephone Number: _____ Relationship to Enrollee: _____</p>			

<b>BROKER</b>	<p><b>X</b></p> <p>Broker Signature _____ Broker Name and ID # (please print) _____ Broker Phone # _____ Date _____</p> <p><b>Please write legibly to ensure correct processing.</b></p>			
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<b>MEDICA USE</b>	<b>Election Period:</b>	Initial Receipt Date	Control Receipt	Deemed Complete	Data Entry Date
	Proposed Eff. Date:				
	Cycle #:				
	County Code:				

WHITE–Medica Copy • YELLOW–Enrollee Copy