

**SOUTH DAKOTA APPLICATION FORM**

**General Medica policy information**

- This application, if approved, will issue an individual/family policy only. The policy is not offered as a group health plan and Medica strictly prohibits it to be used as such.
- Your Social Security Number will be used for the purpose of identification only.
- Any person named on this application who is pregnant or an expectant parent (including adoption) is not eligible for a Medica Direct HSA<sup>SM</sup> or Medica Symphony<sup>SM</sup> plan.
- Online applications are available at **medica.com**. Applying online may reduce your application’s processing time.

**Completing your application**

- Complete all sections within the application thoroughly and accurately. Applications with missing or inaccurate information will be delayed in processing and may result in rescission of your policy.
- Questions in Section F pertain to all persons listed in this application. All questions answered “Yes” in Sections F1 through F4 require a complete explanation in Section F7.

**Submitting your application**

- Submit your premium payment along with your application. If the full first month’s premium payment is not received, your application cannot be processed.
- Please complete, sign and date your application and mail to Medica. All adults, including dependent children age 18 and over, must sign. Primary applicants must be 19 years of age or older.
- Your application form is valid for a period of 60 days from the date you sign it. After 60 days, a new application must be completed in full if you wish to be considered for coverage.
- See Section G for information on your effective date. Medica will notify you if you (or anyone listed in this application) have been approved and the effective date of coverage. The processing time for your application is approximately two to four weeks. **Do not cancel any existing coverage until the Medica policy has been approved, issued and accepted by you.**
- Make a copy of your completed application for your personal records. If you are approved for coverage, this copy will become a part of your contract.

**⚠ Contact us if you have questions**

Please contact a Medica Sales Service Specialist at 952-992-2080 or 1-800-670-5935 between 8:00 a.m. and 5:00 p.m., Monday through Thursday, and 9:00 a.m. and 5:00 p.m. on Friday.

**Thank you for applying for a Medica health plan!**

SECTION

**A CURRENT MEDICA MEMBERSHIP STATUS**

- I am a new applicant not currently covered under a Medica policy.
- I currently have Medica coverage and I want to switch to a different Medica plan.

I am covered under Medica I.D. number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

If your current Medica policy is through your employer, please indicate your employer’s name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

- I currently have a Medica Individual and Family plan and want to add the dependent(s) I’ve listed in Section B.
- I am covered under Medica I.D. number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Primary Applicant's Name:

SECTION

**B APPLICANT INFORMATION**

**Primary Applicant**

Last name:		First name:			Middle initial:	
Marital status:	Preferred telephone number:		Alternate telephone number:		Best time to call:	
<input type="checkbox"/> Single <input type="checkbox"/> Married	+       +	+       +			<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon	

Email address *(by providing you agree that Medica may send you e-mails):*

**Applicant's home address**

Street:	City:	Zip Code:
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**Applicant's billing address** *(if different than home address)*

Street:	City:	Zip Code:
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**Mailing preference**

Please send all mail (other than billing statements) such as my enrollment packet, ID cards and claims information to:

Home address  Billing address

**List each person applying for coverage. Add additional pages if necessary.**

**Note:** Medica Solo is a one-person maximum policy. Medica Direct HSA and Medica Symphony are family policies. Your application will not be processed if you exceed the maximum number of persons allowed on your selected plan.

First name	Middle initial	Last name	Social Security No.	Sex	Relationship to applicant	Birth date <i>mo/day/yr</i>	Height	Present weight	Weight one year ago
				M F	(primary applicant)		ft. in.	lbs.	lbs.
				M F			ft. in.	lbs.	lbs.
				M F			ft. in.	lbs.	lbs.
				M F			ft. in.	lbs.	lbs.
				M F			ft. in.	lbs.	lbs.
				M F			ft. in.	lbs.	lbs.

If you listed any dependents between ages 25–29 in the section above, are they full-time students? . . . . .  Yes  No  
 If "Yes", please list school name and anticipated graduation date:

Primary Applicant's Name:

SECTION C PLAN AND BENEFITS SELECTION

Note: Medica cannot process your application if your Plan and Benefits Selection page is not completed. This page can be found as the last page of your application. You may also find it online at medica.com.

SECTION D PAYMENT INFORMATION

Note: You can find your rate online at medica.com. Your initial payment should reflect the rate quoted online.

Initial payment (first payment must be submitted with this application)

Choose payment method: [ ] Check (make payable to Medica) [ ] Credit Card (submit with the Credit Card Form) Amount paid with this application: \$

Ongoing payments

Choose payment method: [ ] Check [ ] ACH Automatic Payment from your checking account (complete the ACH Authorization Form)

SECTION E OTHER INSURANCE INFORMATION

Note: Incomplete information in this section may result in a pre-existing condition limitation applied to claims for individuals age 19 and older, and a resulting delay in claims payment could occur.

- 1. Would this coverage replace or change any existing health insurance?
2. Is any person named on the application covered by Medicare?
3. Do you currently have any health insurance or have you had any health insurance within the past 63 days?
If Yes, you must provide your health coverage history for the past 12 months by completing the insurance information below:

Table with 5 columns: Coverage start date, Coverage end date, List all persons covered under policy, Name of insurance company, Type of insurance (Individual, Group, COBRA)

SECTION F HEALTH INFORMATION

Note: Any change in applicant's or dependent's health history that occurs between your signature date on this application and the effective date of coverage must be reported to Medica immediately. This includes doctor visits, diagnosed conditions or diseases, or any other medical related issues. This information may be used in determination and/or reversal of policy acceptance. If you do not inform Medica of health changes, your policy may be rescinded. Answer every question in Sections F1 through F4 by checking a "Yes" or "No" box or by checking the health conditions that apply. Complete Section F7 for all conditions checked or all questions answered "Yes" for you and each person applying for coverage.

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

- A. Heart attack, coronary artery disease, heart bypass surgery, angioplasty, heart valve replacement or congestive heart failure?
B. Stroke, aneurysm, carotid artery blockage, Muscular Dystrophy, ALS, or Multiple Sclerosis?
C. Emphysema, chronic obstructive pulmonary disease (COPD) or pulmonary or cystic fibrosis?
D. Hepatitis, cirrhosis of the liver, pancreatitis, Crohn's disease or ulcerative colitis?
E. Diabetes; Type 1 or Type II?
F. Leukemia, Hodgkin's Disease, lymphoma or other type of cancer; including but not limited to breast, colon, kidney, lung or prostate?
G. HIV Positive or AIDS?
H. Rheumatoid arthritis, scleroderma or systemic lupus?
I. Organ transplant?

**F HEALTH INFORMATION (continued)****F2**

**SECTION F2: Within the past 5 years, has any person named on this application been diagnosed with, treated for, or consulted with a physician or practitioner about any of the following (check all boxes that apply):**

**1. Heart, Cardiovascular or Circulatory Disorder**

- |   |  |
|---|--|
| <input type="checkbox"/> a. High Blood Pressure or Hypertension   | <input type="checkbox"/> e. Congenital Heart Condition                                   |
| <input type="checkbox"/> b. Chest Pain or Angina  | <input type="checkbox"/> f. Peripheral Vascular Disease                                  |
| <input type="checkbox"/> c. Heart Murmur, Mitral Valve Prolapse, Heart Valve Condition or Irregular Heartbeat | <input type="checkbox"/> g. Other Cardiovascular, Circulatory or Heart Condition         |
| <input type="checkbox"/> d. Blood Clot, Embolism, Phlebitis or Edema  | <input type="checkbox"/> <b>No to all Heart, Cardiovascular or Circulatory disorders</b> |

**2. Blood, Endocrine, Pituitary or Lymph Node Disorder**

- |   |   |
|---|---|
| <input type="checkbox"/> a. Elevated Cholesterol or Triglycerides                         | <input type="checkbox"/> f. Thyroid disorder or goiter  |
| <input type="checkbox"/> b. Hemochromatosis, High or Low Blood Sugar or Sugar Intolerance | <input type="checkbox"/> g. Recurrence of Enlarged or Swollen Lymph Node                      |
| <input type="checkbox"/> c. Anemia  | <input type="checkbox"/> h. Other Blood, Endocrine, Pituitary or Lymph Node Condition         |
| <input type="checkbox"/> d. Hemophilia  | <input type="checkbox"/> <b>No to all Blood, Endocrine, Pituitary or Lymph Node disorders</b> |
| <input type="checkbox"/> e. Obesity   |   |

**3. Digestive Disorder**

- |  |  |
|--|--|
| <input type="checkbox"/> a. Gastroesophageal Reflux Disease (GERD), Gastritis or Heartburn | <input type="checkbox"/> e. Jaundice   |
| <input type="checkbox"/> b. Stomach Ulcer  | <input type="checkbox"/> f. Other Stomach, Liver, Pancreas, Spleen, Colon or Gallbladder Condition |
| <input type="checkbox"/> c. Irritable Bowel Syndrome (IBS), Chronic Diarrhea or Colitis    | <input type="checkbox"/> <b>No to all Digestive disorders</b>                                      |
| <input type="checkbox"/> d. Diverticulitis, Diverticulosis, Hemorrhoids or Colon Polyps    |  |

**4. Genitourinary Disorder – Kidney, Bladder, Prostate, Urethra, Ureter**

- |  |   |
|--|---|
| <input type="checkbox"/> a. Kidney infection, bladder infection            | <input type="checkbox"/> d. Protein or Blood in Urine             |
| <input type="checkbox"/> b. Kidney stone                                   | <input type="checkbox"/> e. Other Genitourinary Condition         |
| <input type="checkbox"/> c. Prostatitis, Enlarged Prostate or Elevated PSA | <input type="checkbox"/> <b>No to all Genitourinary disorders</b> |

**5. Muscle, Bone, Joint, Immune System Disorder**

- |   |   |
|---|---|
| <input type="checkbox"/> a. Back Pain, Neck Pain, Spine or Disc Condition | <input type="checkbox"/> h. Internal Fixation Device (screws, plates, pins), Prosthesis or Amputation |
| <input type="checkbox"/> b. Knee or Shoulder Condition                    | <input type="checkbox"/> i. Other Muscle, Bone, Joint or Immune System Condition                      |
| <input type="checkbox"/> c. Arthritis, Gout, Bursitis, Tendonitis         | <input type="checkbox"/> <b>No to all Muscle, Bone, Joint, Immune System disorders</b>                |
| <input type="checkbox"/> d. Fibromyalgia or Chronic Fatigue Syndrome      |   |
| <input type="checkbox"/> e. TMJ or Carpal Tunnel Syndrome                 |   |
| <input type="checkbox"/> f. Connective Tissue Disorder                    |   |
| <input type="checkbox"/> g. Polio   |   |

**6. Brain or Nervous System Disorder**

- |  |   |
|--|---|
| <input type="checkbox"/> a. Migraines or Recurrent Headaches     | <input type="checkbox"/> f. Paralysis                                       |
| <input type="checkbox"/> b. Epilepsy, Seizures, Tics or Tremors  | <input type="checkbox"/> g. Cerebral Palsy or Parkinson's                   |
| <input type="checkbox"/> c. Dizziness or Fainting                | <input type="checkbox"/> h. Concussion, Head Trauma, Brain Injury           |
| <input type="checkbox"/> d. Transient Ischemic Attack (TIA)      | <input type="checkbox"/> i. Other Brain or Nervous System Condition         |
| <input type="checkbox"/> e. Alzheimer's, Dementia or Memory Loss | <input type="checkbox"/> <b>No to all Brain or Nervous System disorders</b> |

**7. Congenital or Developmental Disorder**

- |  |   |
|--|---|
| <input type="checkbox"/> a. Cleft Palate or Cleft Lip                    | <input type="checkbox"/> d. Club Foot/Feet                                      |
| <input type="checkbox"/> b. Autism, Down's Syndrome or Mental Disability | <input type="checkbox"/> e. Other Congenital or Developmental Condition         |
| <input type="checkbox"/> c. Developmental Disorder or Delay              | <input type="checkbox"/> <b>No to all Congenital or Developmental disorders</b> |

**F HEALTH INFORMATION (continued)**

**SECTION F2 (continued):** Within the past 5 years, has any person named on this application been diagnosed with, treated for, or consulted with a physician or practitioner about any of the following (check all boxes that apply):

**8. Respiratory Disorder**

- a. Asthma, Allergies, or Hay Fever  
 b. Bronchitis or Pneumonia  
 c. Sleep Apnea  
 d. Shortness of Breath  
 e. Tuberculosis  
 f. Other Respiratory Condition  
 **No to all Respiratory disorders**

**9. Cyst, Growth, Lump, Mass or Tumor**

- a. Melanoma  
 b. Ganglion Cyst  
 c. Cyst, Growth, Lump, Mass or Tumor  
 **No to all Cyst, Growth, Lump, Mass or Tumor conditions**

**10. Female Reproductive System Disorder**

- a. Abnormal Pap Smear  
 b. Abnormal Mammogram  
 c. Infertility  
 d. Endometriosis, Polycystic Ovarian Syndrome (PCOS), Pelvic Inflammatory Disease  
 e. Uterine Fibroids  
 f. Menstrual Condition  
 g. Multiple Miscarriages or Complication of Pregnancy  
 h. Complication of Breast Implants  
 i. Cervical, Ovarian, Uterine or Vaginal Condition  
 j. Other Female Reproductive Condition  
 **No to all Female Reproductive System disorders**

**11. Male Reproductive System Disorder**

- a. Infertility  
 b. Penile or Testicular Condition  
 c. Other Male Reproductive Condition  
 **No to all Male Reproductive System disorders**

**12. Sexually Transmitted Disease**

- a. Genital Warts or Genital Herpes  
 b. Human Papilloma Virus (HPV)  
 c. Chlamydia, Gonorrhea or Syphilis  
 d. Other Sexually Transmitted Disease  
 **No to all Sexually Transmitted Diseases**

**13. Mental, Emotional or Psychological Disorder**

- a. Anxiety, Depression, Panic Disorder  
 b. Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD)  
 c. Anorexia or Bulimia  
 d. Bipolar, Obsessive Compulsive Disorder, Personality Disorder or Schizophrenia  
 e. Psychiatric or Psychological Counseling or Therapy  
 f. Other Mental, Emotional or Psychological Condition  
 **No to all Mental, Emotional or Psychological disorders**

**14. Skin Disorder**

- a. Acne  
 b. Rosacea, Eczema or Psoriasis  
 c. Skin Cancer  
 d. Other Skin Condition  
 **No to all Skin disorders**

**15. Eye, Ear, Nose or Throat Condition**

- a. Cataracts, Glaucoma, Retinitis, Retinal Tear or Blindness  
 b. Recurrent Ear Infections  
 c. Hearing Loss  
 d. Cochlear Implant  
 e. Deviated Nasal Septum, Recurrent Sinusitis  
 f. Recurrent Tonsillitis  
 g. Other Eye, Ear, Nose or Throat Condition  
 **No to all Eye, Ear, Nose or Throat conditions**

SECTION

**F HEALTH INFORMATION (continued)**

**F3**

**SECTION F3: Within the past 5 years, has any person named on this application:**

- A. Been hospitalized? . . . . .  Yes  No
- B. Been evaluated for or treated for alcoholism, chemical dependency, drug abuse? . . . . .  Yes  No
- C. Been advised to have surgery, treatment or testing which has not yet been performed? . . . . .  Yes  No
- D. Had an MRI, CT scan, stress test, echocardiogram, electrocardiogram, X-ray or other diagnostic testing? . . . . .  Yes  No
- E. Been seen by a medical provider for any health condition not already listed on this application (excluding common cold or flu)? . . . . .  Yes  No
- F. Been advised by a medical provider to modify or restrict eating or drinking habits? . . . . .  Yes  No
- G. Been declined coverage, charged an increased rate, or had benefits excluded from a health insurance policy because of a health condition? . . . . .  Yes  No

**F4**

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

- A. Had a positive pregnancy test in the last 90 days, or are currently an expectant parent (male or female), regardless of whether or not the mother is listed on the application? . . . . .  Yes  No
- B. Used tobacco products within the last 12 months? . . . . .  Yes  No
- C. Been convicted for or had a driver's license suspended for DWI/DUI or been convicted for any alcohol or drug-related moving violations within the last 12 months? . . . . .  Yes  No
- D. Currently disabled, hospitalized, on medical leave or receiving disability or workers' compensation benefits? . . . . .  Yes  No

**F5**

**SECTION F5: Please list the date and results of the last physical exam for all persons named on this application:**

Person's name:	Results of exam:	Blood pressure reading:	Physician's name:
Date of physical exam:		Cholesterol reading:	Physician's address:
Person's name:	Results of exam:	Blood pressure reading:	Physician's name:
Date of physical exam:		Cholesterol reading:	Physician's address:
Person's name:	Results of exam:	Blood pressure reading:	Physician's name:
Date of physical exam:		Cholesterol reading:	Physician's address:
Person's name:	Results of exam:	Blood pressure reading:	Physician's name:
Date of physical exam:		Cholesterol reading:	Physician's address:
Person's name:	Results of exam:	Blood pressure reading:	Physician's name:
Date of physical exam:		Cholesterol reading:	Physician's address:

Primary Applicant's Name:

SECTION

**F HEALTH INFORMATION (continued)**

**F6 SECTION F6: Please list all prescription medications filled in the last 12 months for any persons named on this application. Add additional pages if necessary.**

Person's name:	Name of medication:			Currently taking? <input type="checkbox"/> Yes <input type="checkbox"/> No
Reason medication taken:	Generic? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dosage: <input type="checkbox"/> mg <input type="checkbox"/> ml	Number taken each day:	If "No", date stopped:
Person's name:	Name of medication:			Currently taking? <input type="checkbox"/> Yes <input type="checkbox"/> No
Reason medication taken:	Generic? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dosage: <input type="checkbox"/> mg <input type="checkbox"/> ml	Number taken each day:	If "No", date stopped:
Person's name:	Name of medication:			Currently taking? <input type="checkbox"/> Yes <input type="checkbox"/> No
Reason medication taken:	Generic? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dosage: <input type="checkbox"/> mg <input type="checkbox"/> ml	Number taken each day:	If "No", date stopped:
Person's name:	Name of medication:			Currently taking? <input type="checkbox"/> Yes <input type="checkbox"/> No
Reason medication taken:	Generic? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dosage: <input type="checkbox"/> mg <input type="checkbox"/> ml	Number taken each day:	If "No", date stopped:

**F7 SECTION F7: If you checked any health conditions and/or checked "Yes" to any questions in the previous sections, please complete this section and provide us with complete details. Add additional pages if necessary.**

Question number & letter:	Person's name:	Treatment received:			Physician's name:
	Medical condition:	Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No	Onset date:	Complete recovery date:	Physician's address:
Question number & letter:	Person's name:	Treatment received:			Physician's name:
	Medical condition:	Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No	Onset date:	Complete recovery date:	Physician's address:
Question number & letter:	Person's name:	Treatment received:			Physician's name:
	Medical condition:	Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No	Onset date:	Complete recovery date:	Physician's address:
Question number & letter:	Person's name:	Treatment received:			Physician's name:
	Medical condition:	Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No	Onset date:	Complete recovery date:	Physician's address:

Primary Applicant's Name:

SECTION

**G EFFECTIVE DATE OF COVERAGE**

**!** Notes:

- Coverage must start on the 1st day of any month. Coverage can begin the day after the application is received by Medica.
- The effective date must be within 60 days of the application's signature date.
- If no effective date is indicated, your effective date would automatically be the next available effective date.

I'm requesting an effective date of:

Month:

1st

SECTION

**H AUTHORIZATION AND REPRESENTATION**

**TO BE SIGNED BY APPLICANTS**

I represent that the information provided herein is true and complete to the best of my knowledge and belief. I understand that Medica may rescind coverage back to the effective date of coverage for fraud and intentional material misrepresentation.

I authorize any hospital, clinic, institution, physician, insurance company, Intelliscript or other organization, institution or person to give Medica or any of its designees any and all records of information pertaining to medical history or services rendered to Us including, but not limited to, information relating to any Medica records or medical insurance claims, consultations or treatments; outpatient or inpatient hospital services; prescription information and lab work.

I understand that:

1. This information will be used for underwriting, risk rating, enrollment or eligibility for benefits;
2. Medica may re-disclose the information without authorization as permitted by law, which means it may no longer be protected by privacy rules;
3. I may revoke this authorization in writing. Revocation will not affect any actions taken by Medica prior to Medica's receipt of the revocation. Unless revoked, this authorization will remain in effect for the term of my coverage;
4. Benefits under the policy, if approved, will be based upon the selection made in Section C, unless Medica has offered, and I have accepted in writing, 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 alternative plans to some or all of us.
5. I have the right to see and correct my personal information in accordance with the law;
6. I have the right to review Medica's Privacy Notice before signing this application and to request a copy at any time.
7. I authorize Medica to release information related to my Medica enrollment (including information from my medical records) to my insurance broker should I choose to name one. This includes information related to any applicant listed within this application.
8. For individuals age 19 and older, if approved for coverage, a pre-existing condition limitation may apply. If continuous qualifying health coverage has been maintained, this pre-existing condition limitation is in effect for 12 months, but will be reduced based upon length of previous qualifying coverage. If continuous qualifying health coverage has not been maintained, this pre-existing condition limitation is in effect for the first 12 months.

Please keep a copy of your completed application for your records. If you are approved for coverage, this copy will become a part of your contract.

**!**

Signature of Primary Applicant:

Date:

X

As an additional applicant named on this application, I authorize Medica to disclose my protected health information to the Primary Applicant regarding this application.

Signature of Additional Applicant Over Age 18:      Date:

Signature of Additional Applicant Over Age 18:      Date:

X

X

Primary Applicant's Name:

**!** **Note:** Finished filling out your application? Be sure you have all of the following pieces:

1. Original application, including signatures of everyone over the age of 18 who is listed on the application
2. Section C, Plan and Benefits Selection
3. Estimated initial payment for first month's premium

Additional items you may have to your application:

4. Additional pages for Section F, Health Information (if necessary)
5. ACH form (if you are enrolling in automatic payment from your checking account)

**Return completed applications to:**                      **or Fax to:**  
 Medica Insurance Company                                      952-992-2511  
 Mail Route CP312  
 PO Box 9310  
 Minneapolis, MN 55440-9310

SECTION

**J AGENT USE ONLY**

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.

Signature of Agent: X	Date:	Agent number:
Print agent's name:	Telephone number:         +       +	

SECTION

**K FOR OFFICE USE ONLY**

Date received:	Policy effective date:	Plan code:	PE mo.:	Reviewed by: Date:            A D	Payment ID:	Amount:
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**MEDICA PRIVACY NOTICE**

Medica takes its responsibility of protecting your personal information seriously. Where possible, Medica de-identifies or encrypts personal information. We use and disclose personal information only to the extent necessary to conduct treatment, payment and health care operations, or to comply with legal, regulatory or accreditation requirements.

Medica and its business associates obtain, maintain, use and share personal information to carry out certain routine activities. Routine activities include: (i) treatment-related activities, such as referring you to a doctor or other provider; (ii) payment-related activities, such as paying a claim for medical services rendered; and (iii) health care operations, such as professional peer review.

The law also gives you rights to access, copy, and amend your personal information. You have the right to request restrictions on certain uses and disclosures of your personal information. You also have the right to obtain information about how and when your personal information has been used and disclosed.

Medica's full Privacy Notice is available upon request by calling 1-800-670-5935 or by going to [www.medica.com](http://www.medica.com).



Mail Route CP312, PO Box 9310, Minneapolis, MN 55440-9310

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Medica Direct HSA<sup>SM</sup> Medica Symphony<sup>SM</sup> and Medica Solo<sup>SM</sup> are service marks of Medica Health Plans.

**SECTION C PLAN AND BENEFITS SELECTION**

**!** **Note:** Medica cannot process your application if this Plan and Benefits Selection page is not submitted.

**Plan selection:** Select either **Medica Solo<sup>SM</sup>** or **Medica Symphony<sup>SM</sup>** or **Medica Direct HSA<sup>SM</sup>** and complete the additional information below it. Only complete the information within your selected plan's column.

Medica Solo <input type="checkbox"/>	Medica Symphony <input type="checkbox"/>	Medica Direct HSA <input type="checkbox"/>
<b>1. Choose your plan coverage and select your deductible level:</b>		
80% one-person coverage. Select deductible level: <input type="checkbox"/> \$3,000 <input type="checkbox"/> \$6,000 <input type="checkbox"/> \$9,000 <input type="checkbox"/> \$12,000	70% one-person coverage. Select deductible level: <input type="checkbox"/> \$3,000 <input type="checkbox"/> \$6,000 <input type="checkbox"/> \$9,000  70% individual+one coverage. Select deductible level: <input type="checkbox"/> \$6,000 <input type="checkbox"/> \$12,000 <input type="checkbox"/> \$18,000  70% family coverage. Select deductible level: <input type="checkbox"/> \$9,000 <input type="checkbox"/> \$18,000 <input type="checkbox"/> \$27,000	80% one-person coverage. Select deductible level: <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$1,900  80% family coverage. Select deductible level: <input type="checkbox"/> \$3,000 <input type="checkbox"/> \$3,850  100% one-person coverage. Select deductible level: <input type="checkbox"/> \$2,300 <input type="checkbox"/> \$3,000  100% family coverage. Select deductible level: <input type="checkbox"/> \$4,450 <input type="checkbox"/> \$5,750
<b>2. Select your office visit copayment option:</b>		
<i><b>Your copayment is tied to your deductible level</b></i>	<input type="checkbox"/> Option A: \$30 copayment <input type="checkbox"/> Option B: \$60 copayment	<i><b>Not applicable</b></i>
<b>3. Prescription drug coverage option:</b> Choose if you would like to increase your prescription drug coverage. This option is only available at the time of your initial application. This option will be in force for the duration of your policy. <i>Choosing this option increases your monthly rate.</i>		
<input type="checkbox"/> Keep generic-only coverage <input type="checkbox"/> Increase coverage to include brand-name drugs	<i><b>Not applicable</b></i>	<i><b>Not applicable</b></i>