

## Medica Individual and Family Plans

### Wisconsin Application Kit

#### 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 is not eligible for a Medica Solo<sup>SM</sup>, Medica Symphony<sup>SM</sup> or Medica Symphony<sup>SM</sup> for HSA plan.
- Any person named on this application who is an expectant parent (including adoption) is not eligible for a Medica Symphony<sup>SM</sup> or Medica Symphony<sup>SM</sup> for HSA plan.
- Medica Solo is a one-person maximum policy. Medica Symphony and Medica Symphony for HSA are family policies. Your application will not be processed if you exceed the maximum number of persons allowed on your selected plan.
- Online applications are available at [medica.com](http://medica.com). Applying online may reduce your application's processing time.

#### Completing your application kit

- Complete both the Wisconsin Individual Uniform Application and Medica's Supplement to the Uniform Application to apply for coverage. All sections within this application kit must be completed thoroughly and accurately. Applications with missing or inaccurate information will be delayed in processing and may result in rescission of your policy.
- Please write your name on the top of each page within this application kit.
- Questions in Section IV of the Wisconsin Individual Uniform Application pertain to all persons listed in this application. All questions answered "Yes" in Sections IV require a complete explanation in the Additional Medical Details Page.
- List all prescribed medications in the Additional Medical Details Page.

#### 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 the Wisconsin Individual Uniform Application and Medica's Supplement to the Uniform Application and mail this kit back 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 E of Medica's Supplement to the Uniform Application 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.**
- 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.
- 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!

**INDIVIDUAL UNIFORM APPLICATION  
FOR INDIVIDUAL MAJOR MEDICAL  
HEALTH INSURANCE FORM**



**State of Wisconsin  
Office of the Commissioner of  
Insurance  
P.O. Box 7873  
Madison, WI 53707-7873  
(608) 266-3585  
Web Address: oci.wi.gov**

Ref: Section Ins 3.33, Wis. Adm. Code,  
and s. 601.41 (10), Wis. Stat.

***This form is designed for an individual's initial application for coverage. Please contact the insurer with questions regarding this form.***

**Instructions: Please complete the entire application for each person for whom coverage is being sought. If a person is currently enrolled in Medicare, this application should not be completed for that enrolled individual. If additional pages are needed to fully complete this application, please attach, sign and date each page.**

**I. INFORMATION**

**Primary Applicant/Insured Information:**

First, Middle and Last Name				
Social Security No.*	Place of Birth	Birth Date	Gender	Height _____ Weight _____
Residential Address				
City	County	State	Zip Code	
Mailing Address, if different from residential address				
City	County	State	Zip Code	
Home Phone	Alternative Phone		Email (Optional)	
*If you have a Social Security Number.				
<b>The Primary Applicant is:</b>				
[ ] Single [ ] Married [ ] Under the age of 18**				
**If primary applicant is under the age of 18, please complete sections – II. C. and V.				
<b>Employment Information:</b>				
Primary job duties:				
Self-Employed: [ ] Yes [ ] No				

**II. ADDITIONAL APPLICANTS**

**A. Please complete ONLY if your spouse and/or children under the age of 27 are applying for coverage. If there is not enough space provided, please attach additional family information. Please sign and date the additional sheet.**

Spouse Name (First; M.I.; Last)	Gender	Social Security Number*/ Place of Birth	Birth Date (Mo/Day/Yr)	Height Weight	Primary Job Duties (if applicable)

\* If you have a Social Security number.

Primary Applicant's Name:

Child Name (First; M.I.; Last)	Gender	Social Security Number*	Birth Date (Mo/Day/Yr)	Height Weight	Primary Job Duties (if applicable)

\* If you have a Social Security number.

**B.** Does the child(ren) named within this application live with you at the address shown above?  
[ ] Yes [ ] No If "No," please list the child(ren)'s name and mailing address(es):

Mailing Address Named Applicant

City	County	State	Zip Code
Home Phone		Alternative Phone	
Name of the Legal Guardian or Parent responsible for carrying health insurance for the minor child.			

**C.** If the primary applicant is under the age of 18, provide the name and mailing address of the legal guardian or custodial parent:

Mailing Address Legal Guardian or Custodial Parent

City	County	State	Zip Code
Home Phone		Alternative Phone	
Name of the Legal Guardian or Parent responsible for carrying health insurance for the minor child			

### III. CURRENT AND PREVIOUS COVERAGE

Please provide information about you or your dependent's individual or group health insurance coverage or other health coverage (either prior or current). It will help us determine whether you will have any waiting periods for preexisting conditions for the health insurance you are applying for. By providing this information you are not reducing your health insurance.

**Does anyone applying for coverage have current health coverage?**

[ ] Yes [ ] No If "Yes," please indicate insurer and applicant \_\_\_\_\_.

Primary Applicant's Name:

**Has any applicant had health insurance coverage within the last 18 months?**

Yes  No If "Yes," please indicate insurer and applicant \_\_\_\_\_.

**If any applicant has current health coverage, will that applicant cancel current coverage if this applicant is accepted?**

Yes  No

**Is any applicant enrolled in Medicare?**

Yes  No If "Yes," name of applicant \_\_\_\_\_. For this applicant, please stop here – this insurance may duplicate existing Medicare coverage.

**Is any applicant enrolled in Medicaid or other governmental health programs (i.e. BadgerCare, TRICARE, Veterans services)?**

Yes  No If "Yes," name of applicant \_\_\_\_\_. For this applicant, please be aware that obtaining individual health insurance may affect this individual's Medicaid status.

#### IV. MEDICAL INFORMATION

##### NOTICE TO APPLICANT:

The insurance company does not use or collect genetic information for any Underwriting purpose. Genetic information includes information related to genetic tests, genetic counseling, and any family history of a disease or disorder. Any such information should not be included on an application or communicated to the insurance company in any manner. For the purpose of these questions, *chronic* means persistent, continuous, or periodic, or a combination of any of these terms.

You are required to disclose information regarding any disease or condition for which:

- Any applicant has been diagnosed or treated by any healthcare provider.
- Any applicant has had testing with abnormal results.
- Any applicant is awaiting test results.
- Any applicant has been recommended or scheduled for diagnostic testing, consultation, treatment, follow-up, or surgery.
- Any applicant has taken or has been advised to take any prescription medication.
- Any change in health status for which any applicant has not sought medical care or treatment.

Within the last FIVE (5) YEARS has anyone, including you or any family member requesting coverage, received counseling, care or treatment, medication, medical advice or been told a diagnosis for any of the conditions or illnesses listed below? (Please check all conditions that apply.)

Please mark "Yes" or "No" for each item, for you and any family members requesting coverage. Provide additional information for each question you answer "Yes" to on the Additional Medical Details page that follows the health questions.

**Answers to the medical questions should be complete, true and correct to the best of your knowledge. You are required to promptly notify us if there is a change in your or your family's health prior to the effective date of coverage and provide updated information. If at any time during the underwriting process prior to the effective date of coverage, you or your health history changes, please notify us immediately as this may impact your coverage.**

##### WITHIN THE LAST FIVE (5) YEARS:

##### 1. Infectious and Parasitic Diseases

- a. AIDS (acquired immunodeficiency syndrome), ARC (AIDS-related complex), HIV positive [The reporting of HIV test results is limited to FDA-licensed tests, and you need not report results of tests conducted at an anonymous counseling and testing site or through the use of a home test kit.] .....  Yes  No

Primary Applicant's Name:

b. Lyme's Disease ..... [ ] Yes [ ] No

c. Sexually transmitted disease(s)..... [ ] Yes [ ] No

**2. Blood, Gland, Endocrine, Metabolic and Immune Disorders (other than HIV, ARC, AIDS)**

a. Anemia/blood disorder..... [ ] Yes [ ] No

b. Thyroid disease ..... [ ] Yes [ ] No

c. Diabetes/high or low blood sugar. .... [ ] Yes [ ] No  
(If "Yes," record last HGA1C reading and date on the Additional Medical Details page.)

d. Adrenal disorder ..... [ ] Yes [ ] No

e. Enlargement of lymph nodes ..... [ ] Yes [ ] No

f. Endocrine/gland/hormone system ..... [ ] Yes [ ] No

**3. Cancer, Cyst and Tumors**

c. Cancer. .... [ ] Yes [ ] No  
(If "Yes," include the stage, type and location of the tumor on the Additional Medical Details page.)

b. Tumors, cyst, lump, polyp..... [ ] Yes [ ] No

**4. Mental/Nervous/Behavioral Disorders**

a. Alcohol/chemical/drug abuse/dependency ..... [ ] Yes [ ] No

b. Has any applicant used sedatives; tranquilizers; cocaine or other hallucinogenic or narcotic drugs?..... [ ] Yes [ ] No

c. Eating disorders such as, but not limited to, anorexia or bulimia ..... [ ] Yes [ ] No

d. Mental/emotional condition/depression ..... [ ] Yes [ ] No

e. Autism ..... [ ] Yes [ ] No

f. Suicide attempt ..... [ ] Yes [ ] No

g. Alcohol, chemical, drug abuse therapy, treatment or counseling within last 5 years..... [ ] Yes [ ] No  
(if "Yes," record date of last session in on the Additional Medical Details page)

**5. Brain and Nervous System**

a. Brain disease or injury/concussion ..... [ ] Yes [ ] No

b. Convulsion/seizures/epilepsy ..... [ ] Yes [ ] No

c. Chronic headaches/migraines ..... [ ] Yes [ ] No

d. Neurological condition/disease/injury ..... [ ] Yes [ ] No

e. Sleep apnea/chronic sleep disorder ..... [ ] Yes [ ] No

f. Stroke ..... [ ] Yes [ ] No

g. Multiple Sclerosis ..... [ ] Yes [ ] No

h. Paralysis ..... [ ] Yes [ ] No

**6. Skin Disorders**

a. Skin condition, abnormal or cancerous moles or eczema/cysts/cancer..... [ ] Yes [ ] No

**7. Eyes, Ears, Nose**

a. Chronic ear/nose condition/disease ..... [ ] Yes [ ] No

Primary Applicant's Name:

b. Chronic eye condition/disease..... [ ] Yes [ ] No

c. Cataracts/glaucoma ..... [ ] Yes [ ] No

**8. Mouth, Throat or Jaw**

a. Chronic throat/tonsil/adenoid/disease/disorder ..... [ ] Yes [ ] No

b. TMJ/jaw joint..... [ ] Yes [ ] No

**9. Heart or Circulatory System**

a. Blood/circulatory disorder ..... [ ] Yes [ ] No

b. Heart attack/chest pain/murmur/angina..... [ ] Yes [ ] No

c. Elevated/High cholesterol ..... [ ] Yes [ ] No  
(if "Yes," record last reading and the date on the Additional Medical Details page)

d. Elevated/High or low blood pressure..... [ ] Yes [ ] No  
(if "Yes," record last 3 readings and dates in past 12 months on the Additional Medical Details page)

e. Phlebitis/blood clot..... [ ] Yes [ ] No

f. Heart disease/disorder ..... [ ] Yes [ ] No

**10. Respiratory System**

a. Asthma..... [ ] Yes [ ] No

b. Emphysema/Chronic obstructive pulmonary disease (COPD)..... [ ] Yes [ ] No

c. Chronic respiratory/lung condition ..... [ ] Yes [ ] No

d. Pneumonia/bronchitis ..... [ ] Yes [ ] No

**11. Digestive System**

a. Appendicitis/chronic abdominal pain ..... [ ] Yes [ ] No

b. Blood in stool ..... [ ] Yes [ ] No

c. Colon/rectum/intestine/bowel/Crohn's disease..... [ ] Yes [ ] No

d. Ulcer/esophageal reflux..... [ ] Yes [ ] No

e. Gallbladder ..... [ ] Yes [ ] No

f. Liver condition/hepatitis/pancreas ..... [ ] Yes [ ] No

**12. Urinary System**

a. Bladder/urinary tract ..... [ ] Yes [ ] No

b. Kidney/kidney stones..... [ ] Yes [ ] No

**13. Male or Female Reproductive Systems**

a. Breast (lumps or masses)..... [ ] Yes [ ] No

b. Prostate/elevated PSA/prostatitis ..... [ ] Yes [ ] No

c. Reproductive system disorder/infertility/dysfunction..... [ ] Yes [ ] No

d. Abnormal pap smear or mammography ..... [ ] Yes [ ] No

**14. Pregnancy, Birth or Congenital Abnormalities**

a. Birth defect/congenital deformities ..... [ ] Yes [ ] No

b. Pregnancy complications ..... [ ] Yes [ ] No

Primary Applicant's Name:

c. Are you, your spouse or any dependent child(ren) (even if not listed on the application) currently pregnant or an expectant parent? (If "Yes," due date \_\_\_\_\_.) .....  Yes  No

**15. Muscular or Skeletal System**

- a. Back/neck/spine disorder .....  Yes  No
- b. Bone/orthopedic disorder .....  Yes  No
- c. Lupus, chronic muscle pain, muscle injury or disease, or fibromyalgia.....  Yes  No
- d. Osteoarthritis/osteoporosis/osteopenia .....  Yes  No
- e. Rheumatoid arthritis.....  Yes  No
- f. Knee/shoulder/hip/joint surgery/disorder .....  Yes  No
- g. Hernia .....  Yes  No

**16. Miscellaneous**

- a. Cosmetic surgery/implants .....  Yes  No
- b. Use of prosthetic devices/limbs .....  Yes  No
- c. Had chronic fatigue .....  Yes  No
- d. Is any person to be insured now disabled, on disability, or unable to perform normal work or age-related activities .....  Yes  No
- e. Any fluctuations in weight (+/- 20lbs) in the past 12 months .....  Yes  No
- f. Implantable devices/stents/shunts/pace maker.....  Yes  No
- g. Allergies .....  Yes  No
- h. Transplants .....  Yes  No

**17. Other Injury, Illness, Treatment or Condition**

a. Within the last 5 years, has any applicant had any other injury, illness, treatment, or condition not already listed; been hospitalized or scheduled to be hospitalized; had surgery or had surgery scheduled; had a test or a test scheduled; been recommended to have a test or surgery that was not performed for any reason not already mentioned; been prescribed medication for a condition or injury not already mentioned? (We are NOT seeking the results of HIV Antibody test.) .....  Yes  No

**18. Tobacco Use**

a. Has any applicant used tobacco products in any form within the last 12 months?..  Yes  No  
If "Yes", provide the name of applicant(s), amount of tobacco used and frequency:

**19. Other Activities**

a. Has any applicant been involved in or participated in organized motorized racing or other extreme activities? .....  Yes  No  
If "Yes", provide the name of applicant(s), activity and frequency of the activity:

**ONLY complete this section if you need assistance with completing the medical information portion of this Application. Please note that this may require additional time to process your application.**

Please contact me at this phone number during business hours:

Primary Applicant's Name:

I am unavailable during business hours, please contact me at this number during evenings or weekends:

**Additional Medical Details Page**

For any "Yes" responses in the medical information questions, please provide complete details below. Not providing complete details will delay the application process. Within the last five years has anyone been prescribed medications that were recommended or received from a licensed health care professional? Use an additional sheet(s) of paper if necessary.

**All additional pages must be signed and dated by the primary applicant.**

<b>Question # or additional information</b>								
<b>Applicant Name</b>								
<b>Specific Diagnosis &amp; Type of Treatment</b>								
<b>Duration of Condition</b>	<b>Began mm/yy</b>		<b>Began mm/yy</b>		<b>Began mm/yy</b>		<b>Began mm/yy</b>	
	<b>End mm/yy</b>		<b>End mm/yy</b>		<b>End mm/yy</b>		<b>End mm/yy</b>	
<b>Name/ Dosage/ Frequency of medication &amp; Dates of Medication Use</b>	<b>Name of Rx</b>		<b>Name of Rx</b>		<b>Name of Rx</b>		<b>Name of Rx</b>	
	<b>Dose</b>		<b>Dose</b>		<b>Dose</b>		<b>Dose</b>	
	<b>Began mm/yy</b>	<b>End mm/yy</b>	<b>Began mm/yy</b>	<b>End mm/yy</b>	<b>Began mm/yy</b>	<b>End mm/yy</b>	<b>Began mm/yy</b>	<b>End mm/yy</b>
<b>Was surgery performed</b>								
<b>Description of surgery/ Procedures/ Tests/Result &amp; Dates</b>								
<b>Current Status/ O-Ongoing/ R-Resolved</b>								
<b>Readings for Blood Pressure, Cholesterol &amp; Diabetes</b>	<b>Date</b>	<b>Reading</b>	<b>Date</b>	<b>Reading</b>	<b>Date</b>	<b>Reading</b>	<b>Date</b>	<b>Reading</b>
<b>Physician/ Hospital Name, City, State</b>								

Primary Applicant's Name:

**V. TERMS AND CONDITIONS**

I acknowledge that I have read and completed the entire Application. If I received assistance in reading or completing this Application, I have identified the person(s) who assisted me. I agree that the answers are, to the best of my knowledge and ability, complete and true.

I understand that my answers, together with any supplements or additional pages, are the basis for the certificate or policy that is issued. I agree that no insurance will be effective until the date specified by the insurance company on the certificate or policy.

I understand that any intentional misrepresentation relied upon by the insurer may be used to deny a claim. I further understand that this contract can be voided if within the first 24 months from the date of the policy or certificate it is determined that I or a family member made an intentional misrepresentation in the application.

I understand that it may be a crime to submit an application or file a claim based on a false or deceptive statement. I further understand it may be a crime to submit an application that is intended to mislead an insurer or conceal significant information about the applicant.

I understand that I may request a copy of this Application and the notice of the company's privacy practices. I agree that a photocopy is as valid as an original. A legible facsimile or electronic signature shall have the same force as the original.

<b>Signature (or e-signature) of Primary Applicant</b> (If Primary Applicant is under the age of 18, Signature of legal guardian or custodial parent)	<b>Date Signed</b>
<b>Signature (or e-signature) of Spouse</b>	<b>Date Signed</b>

**Signature (or e-signature) of each listed child who has attained the age of 18**

<b>Signature (or e-signature) of an Adult Child Applicant</b>	<b>Date Signed</b>
<b>Signature (or e-signature) of an Adult Child Applicant</b>	<b>Date Signed</b>
<b>Signature (or e-signature) of an Adult Child Applicant</b>	<b>Date Signed</b>

**Complete this section if someone assisted you in the completion of this Application**

The following person assisted me in completing the Application:
Please explain the assistant's relationship to you and your family:

Individual Uniform Application Form  
OCI 26-503 (c. 06/2010)

**SUPPLEMENT TO THE WISCONSIN UNIFORM APPLICATION**

SECTION

**A APPLICANT INFORMATION**

**Primary Applicant**

Last name:	First name:	Middle initial:	Birth date (mm/dd/yyyy)
			+     +

**Best time to call:**

**Mailing preference**

- Morning
- Afternoon

Please send billing statements to the following address as provided on the Individual Uniform Application:  
 Residential Address    Mailing Address

SECTION

**B 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:

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- I currently have a Medica Individual and Family plan and want to add the dependent(s) I've listed on the Wisconsin Individual Uniform Application. I am covered under Medica I.D. number:

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

SECTION

**C 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? . . . . .  Yes    No
  2. Do you currently have any health insurance or have you had any health insurance within the past 63 days? . . . . .  Yes    No
- If Yes, you **must** provide your health coverage history for the past 12 months by completing the insurance information below:

Coverage start date (mm/dd/yyyy)	Coverage end date (mm/dd/yyyy)	List all persons covered under policy	Name of insurance company	Type of insurance
				<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> COBRA
				<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> COBRA

Primary Applicant's Name:

SECTION

## D PLAN AND BENEFITS SELECTION

**!** **Note:** Medica cannot process your application if this Plan and Benefits Selection page is not submitted. This information is valid July 2011 through June 2012.

**Plan selection: Select Medica Solo<sup>SM</sup>, Medica Symphony<sup>SM</sup> or Medica Symphony<sup>SM</sup> for HSA 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 Symphony for 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	100% one-person coverage. Select deductible level: <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$7,000 <input type="checkbox"/> \$10,000  100% family coverage. Select deductible level: <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$14,000 <input type="checkbox"/> \$20,000	80% one-person coverage. Select deductible level: <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$3,000 <input type="checkbox"/> \$5,000  80% family coverage. Select deductible level: <input type="checkbox"/> \$3,000 <input type="checkbox"/> \$5,500 <input type="checkbox"/> \$8,000  100% one-person coverage. Select deductible level: <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$3,300 <input type="checkbox"/> \$4,600 <input type="checkbox"/> \$5,900  100% family coverage. Select deductible level: <input type="checkbox"/> \$4,000 <input type="checkbox"/> \$7,000 <input type="checkbox"/> \$9,500 <input type="checkbox"/> \$11,900
<b>2. Select your office visit copayment option:</b>			
	<i>Your copayment is tied to your deductible level</i>	<input type="checkbox"/> Option A: \$30 copayment <input type="checkbox"/> Option B: \$60 copayment	<i>Not applicable</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 Tier 1-only coverage <input type="checkbox"/> Increase coverage to include Tier 2 and 3	<input type="checkbox"/> Keep Tier 1-only coverage <input type="checkbox"/> Increase coverage to include Tier 2 and 3	<i>Not applicable</i>

SECTION

## E EFFECTIVE DATE OF COVERAGE

- !** **Notes:**
- Coverage must start on the 1st 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:	<input type="checkbox"/> 1st
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Primary Applicant's Name:

SECTION

**F 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

**G 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;
5. 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.
6. I have the right to see and correct my personal information in accordance with the law;
7. I have the right to review Medica's Privacy Notice before signing this application and to request a copy at any time.
8. 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.
9. 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: \_\_\_\_\_  
X

Signature of Additional Applicant Over Age 18: \_\_\_\_\_ Date: \_\_\_\_\_  
X

Primary Applicant's Name:

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

1. State of Wisconsin Individual Uniform Application
2. Medica's Supplement to the Uniform Application
3. Estimated initial payment for first month's premium

Additional items you *may* have with your application:

4. Additional pages for Medical Information (*if necessary*)
5. ACH form (*if you are enrolling in automatic payment from your checking account*)

**Return your completed Wisconsin Individual Uniform Application and Medica's Supplement to the Uniform Application to:**

**or Fax to:**  
952-992-2511

Medica Insurance Company  
Mail Route CP312  
PO Box 9310  
Minneapolis, MN 55440-9310

SECTION

## H 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

## I 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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