Medica Group Medicare Plan

2019 Group Enrollment Application Form for:

Medica Group Prime Solution℠ (Cost) Plan & Medica Group Advantage Solution℠ (PPO) Plan

Medica Group Prime Solution℠ is a Medicare Cost product offered by Medica Insurance Company ("Medica"), an insurance company licensed by the states of Minnesota, North Dakota, South Dakota and Wisconsin, that holds a Medicare contract. Medica Group Prime Solution is an employer/union sponsored health plan.

Medica Group Advantage Solution℠ is a Medicare Advantage product offered by Medica Health Plans.

Important Information:

- Please consult the Summary of Benefits for enrollment requirements and details on the plan. You must have Medicare Part B to be enrolled in Medica Group Prime Solution Cost and Medicare Parts A and B to be enrolled in Medica Group Advantage Solution. You must continue to pay your Medicare Part B premium.
- If you have any questions concerning your application or if you need information in another language or format (like Braille or large print), please contact Medica from 8 a.m. to 8 p.m. Central Time, seven days a week, at 1-800-918-2416 (TTY: 711). Access to representatives may be limited at times.
- You can only be in one Medicare health plan at a time. By joining Medica Group Prime Solution or Medica Group Advantage Solution, your membership in any other Medicare Advantage or Medicare Cost plan will end. This will affect both your doctor and hospital coverage as well as your prescription drug benefits.
- If you currently have health coverage from an employer or union, joining Medica Group Prime Solution or Medica Group Advantage Solution with prescription drug coverage may affect your employer or union health benefits. You could lose your employer or union health coverage if you join Medica Group Prime Solution or Medica Group Advantage Solution. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.
- If you are assessed a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security or Railroad Retirement Board benefit check or be billed directly by Medicare. Do NOT pay the Part D-IRMAA extra amount to Medica.
- To enroll, please make sure you have completed and forwarded all necessary information to Medica. 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 or blue pen and print firmly.

Return completed applications to:	**OR**	**Fax to:**	**OR**	**Securely upload online at:**
Medica Medicare Solutions PO Box 6300 Eau Claire, WI 54702-9713		1-855-250-2166		www.medica.com/EnrollmentUpload

MEDICA®

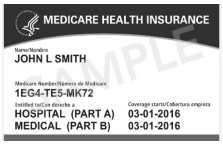
WHITE – Medica YELLOW – Applicant

2019 Medica Group Medicare Plan

Sponsoring Group Name	Plan Number	Proposed Effective Date

■ Section 1: Medicare information *Your enrollment form cannot be processed without this information*

Please take out your red, white and blue Medicare card to complete this section.



- Fill out this information as it appears on your Medicare card.

-OR-

- Attach a copy of your Medicare card or your letter from the Social Security or the Railroad Retirement Board.

MEDICARE HEALTH INSURANCE

Name:_____

Medicare Number: Sex:

_____ _____

Is Entitled to: Effective Date:

HOSPITAL (Part A): _____

MEDICAL (Part B): _____

■ Section 2: Print your name exactly as it appears on your Medicare card.

Legal First Name	M.I.	Last Name	Sex ❑ Male ❑ Female

Permanent Residence Address	City	State	ZIP	County
Mailing Address *if different from above*	City	State	ZIP	County

Primary Telephone *with area code*	Secondary Telephone *with area code*	Birthdate __ __ / __ __ / __ __ __ __ M M / D D / Y Y Y Y

Email Address *optional – by providing you agree that Medica may send you emails*	Preferred Language

■ Section 3: Please answer these questions

(This information is required to process your application and is NOT used for health screening)

1. ❑ **YES** ❑ **NO** Do you have End-Stage Renal Disease (ESRD)?

   ESRD is kidney disease requiring dialysis. You cannot enroll in this plan if you have ESRD, unless: A) you are enrolled in a Medica plan as a non-Medicare member and you developed ESRD while a Medica member; or B) you have had a successful kidney transplant and no longer require dialysis (please attach a note or records from your doctor showing you do not need dialysis or have had a successful kidney transplant).

2. ❑ **YES** ❑ **NO** Are you a resident in a long-term care facility, such as a nursing home

   If "yes" please provide the following information.

   Name of Institution: _____

   Address & Phone Number of Institution (number and street address):

   _____

■ Section 4: Payment method (Please do not submit payment with your application)

Please choose a payment method: (If you don't select a payment method, you will receive a bill each month)

❑ **Monthly invoicing**

❑ **Monthly automatic withdrawals from your checking or savings account**
Withdrawals take place on the fifth business day of each month.

Account Type: ❑ **Checking** *(attach a voided check)* ❑ **Savings** *(attach a deposit slip)*	Financial Institution Name:

The "account holder" information below is required if you are not the account holder.

Account Holder Name:	Account Holder Telephone Number:
Account Holder Signature:	

Note: People with limited incomes may qualify for *Extra Help* to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this *Extra Help*, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for *Extra Help* online at www.socialsecurity.gov/prescription help.

If you qualify for *Extra Help* with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

■ Section 5: Sign and date

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 acknowledge, accept receipt of, and understand the meaning of this application, the statements of understanding on page 5 of this application, and the Medica Group Prime Solution Summary of Benefits or Medica Group Advantage Solution Summary of Benefits. If signed by an authorized individual (as described above), this signature represents that, to the best of that individual's knowledge and belief: 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 by Medicare.

X _____ ___/___/____

Applicant or Authorized Representative Signature — Today's Date

If you are the authorized representative, you must provide the following information:

Name: _____ Address: _____

Telephone Number: _____ Relationship to Enrollee: _____

■ Agent use only

_____ _____

Agent Name (please print) — ID Number

X _____ _____ _____/_____/_____

Agent Signature — Agent Telephone — Agent's Receipt Date

■ Statements of Understanding

By completing Section 5, I authorize Medica, its claims administrator, the Centers for Medicare and Medicaid Services (and its designee(s)), plans, brokers of record, providers and any other person or entity to share my health information with each other as is necessary for treatment, payment and health care operations. I also authorize this information, including prescription drug information, to be released to Medicare who may release it for research and other purposes which follow all applicable federal law. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by applicable privacy rules. I further understand that I have the right to revoke this authorization, at any time, by contacting Medica in writing. Medica conditions enrollment on this authorization and my revocation or failure to provide authorization may affect my enrollment. However, if I revoke this 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.

I further understand and agree that:

1. Medica Group Prime Solution℠ is a Cost Plan and Medica Group Advantage Solution℠ is a Medicare Advantage Plan and have contracts with the Federal government. I will need to keep my Medicare Part B to be enrolled in Medica Group Prime Solution and Medicare Parts A and B to be enrolled in Medica Group Advantage Solution. I can be in only one Medicare plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. I understand that my enrollment in a Medigap plan will not automatically end.
2. I can only be in one Medicare prescription drug plan at a time. If I am currently in a Medicare prescription drug plan, my enrollment in this Medica Group Medicare Plan with Part D will end that enrollment.
3. Generally I may request to disenroll from Medica Group Prime Solution or Medica Group Advantage Solution only at certain times of the year by sending a written request to Medica or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY: 711).
4. **Medica Group Advantage Solution** serves a specific service area. If I move out of that area, I need to notify Medica so I can disenroll and find a new plan in my new area.
5. **Medica Group Prime Solution** serves a specific service area and 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.
6. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.
7. Medica Group Prime Solution or Medica Group Advantage Solution will send me written notification of the effective date of my enrollment.
8. Once I am a member of Medica Group Prime Solution or Medica Group Advantage Solution, I have the right to appeal plan decisions about payment of coverage for services with which I disagree. I will read the Evidence of Coverage from Medica to know which rules I must follow in order to receive coverage under Medica Group Prime Solution or Medica Group Advantage Solution. The premium and copayment amounts were stated to me, and may also be found in the Evidence of Coverage.
9. Beginning on the date Medica Prime Solution coverage starts, 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 or for out-of-area renal dialysis. If I obtain routine services from non-network providers that are not authorized for coverage by Medica under the plan, I will be responsible for all Medicare deductibles and coinsurance, as well as any additional charges as prescribed by the Medicare program. I may also be liable for charges not covered by Medicare.

   I understand that beginning on the date Advantage Solution coverage starts, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-area dialysis services.

10. Services authorized by Medica and other services contained in the Medica Evidence of Coverage document will be covered. Without authorization, neither Medicare nor Medica will pay for the services.
11. Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare plan options as well as medical assistance through the state Medicaid program and the Medicare Savings Program.
12. If I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Medica, he/she may be paid based on my enrollment in Medica Group Prime Solution or Medica Group Advantage Solution.

The information on this form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

MEDICA®

PO Box 9310, Minneapolis, MN 55440-9310

Medica is a Cost and PPO plan with a Medicare contract. Enrollment in Medica depends on contract renewal.

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