



Receive Quotes



Compare Plans



Apply Now

- When completing the health history application, try to answer all medical questions with as much detail as possible. Don't worry about leaving anything blank – we will review your application upon receipt and let you know if you missed anything.
- Keep in mind the underwriting process can take up to six weeks. If the underwriter requests medical records, the decision could take longer (up to 60 days). If you need coverage right away, call us or visit our website to sign up for short-term medical insurance (coverage can start as early as midnight tonight).
- Please review the following chart for payment details:

	MEDICA	MCHA	BLUE CROSS	HEALTH PARTNERS
1 st Month's Premium required with application	✓	✓	✓	
Automatic withdrawal required for monthly payment	✓	✓	✓	✓

**Checks must be written from a personal account; however, there are exceptions to this rule. Please contact an InsuranceSmart representative for details. All checks are payable to the insurance carrier NOT InsuranceSmart.*

- Sign and date application. Applications must be received by the home office of the insurance company within 15 days of the signature date.
- Return the application to:

InsuranceSmart

9220 Bass Lake Rd, Suite 300

New Hope, MN 55428

Fax 763-577-0358 (HealthPartners applications may be received via fax)

We will send a confirmation notice upon receipt of your application. Do not cancel your existing medical policy until you have verification that your new policy has been approved. Should you be declined coverage, you may qualify for the Minnesota Comprehensive Health Association (MCHA) Plan. Please contact an InsuranceSmart representative for more details.

We look forward to servicing your insurance needs. Please don't hesitate to contact us at 763-550-0638 or 800-645-6920 with any questions or concerns you may have.

INSURANCE SMART

9220 Bass Lake Road, Ste 300 – New Hope, MN 55428

763-550-0638 or 800-645-6920 Fax 763-577-0358

www.InsuranceSmartOnline.com ■ MN Lic #IA-20018362

**PLEASE TYPE OR PRINT CLEARLY
USING BLUE OR BLACK INK.**

1) Applicant's name (<i>Last, First, Middle</i>)				2) Marital status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated		
3) Applicant's home address		<i>Street</i>	<i>City</i>	<i>State</i>	<i>ZIP</i>	<i>County</i>
4) Billing address (<i>if different from #3</i>)		<i>Street</i>	<i>City</i>	<i>State</i>	<i>ZIP</i>	<i>County</i>
5) E-mail address		6) Home telephone no. ()		7) Cellular telephone no. ()		Best time to call: ___ A.M. ___ P.M.

8) Please indicate your current eligibility status:
 I was born in the United States
 I am a legal U.S. citizen under Naturalization
 I have been a permanent U.S. resident for at least one year (with a Green Card)
 Other (please explain):

9) Are you a permanent resident of Minnesota currently residing in Minnesota? Yes No
 If "No," please explain:

10) Occupation (<i>Applicant</i>)		Company name	Hours worked per week _____ <input type="checkbox"/> Full time <input type="checkbox"/> Part time	Work telephone no. ()
Duties			Self employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Covered by Worker's Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No
11) Occupation (<i>Spouse</i>)		Company name	Hours worked per week _____ <input type="checkbox"/> Full time <input type="checkbox"/> Part time	Work telephone no. ()
Duties			Self employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Covered by Worker's Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No

12) Reason for application (complete one):
 I am a new applicant presently not covered under a Medica policy.
 I presently have Medica coverage. I am covered under I.D. number
 I presently have Medica Direct for Individuals coverage and want to add my dependent(s) listed below. My policy identification (I.D.) number is

B. APPLICANT AND DEPENDENT INFORMATION

1) List each person for whom application is being made. Add additional page if more space is needed.

First name	Middle initial	Last name	Social Security No.	Sex	Relationship to applicant	Birth date mo/day/yr	State of birth	Height	Present weight	Weight one year ago
A.				M F	(applicant)			ft. in.	lbs.	lbs.
B.				M F				ft. in.	lbs.	lbs.
C.				M F				ft. in.	lbs.	lbs.
D.				M F				ft. in.	lbs.	lbs.
E.				M F				ft. in.	lbs.	lbs.

2) Does any person named on this application live outside the above household? Yes No
 If "Yes," explain: _____

3) Are any household members not to be covered here? Yes No
 If "Yes," please explain why: _____

C. BENEFIT SELECTION (select either HSA or Value and fill out appropriate section)

MEDICA DIRECT HSA FOR INDIVIDUALS

1) Select your choice of the following coinsurance plan and calendar year deductible.

80% Plan

- \$1,400 Individual Coverage/
\$2,800 Family (2 or more)
Coverage
- \$1,800 Individual Coverage/
\$3,650 Family (2 or more)
Coverage

100% Plan

- \$1,800 Individual Coverage/
\$3,650 Family (2 or more)
Coverage
- \$2,400 Individual Coverage/
\$4,500 Family (2 or more)
Coverage
- \$2,850 Individual Coverage/
\$5,500 Family (2 or more)
Coverage
- \$3,500 Individual Coverage/
\$7,000 Family (2 or more)
Coverage

2) **First Dollar Preventive Election** – I want to **include**, at an additional cost, First Dollar Preventive Care Coverage. The coverage includes the following preventive services: routine physicals, routine eye exams, health education services and cancer screenings. I understand that the deductible, and if applicable, coinsurance does not apply for the first \$300 in benefits paid on a calendar year basis for each covered person. I understand this election applies to all persons for whom application is being made. I also understand that this election will be in force for the duration of my policy. Note: If you do not choose this election, preventive care (except for prenatal and well child services) is subject to deductible before benefits are paid. Yes No

3) **Mental Health Coverage Election** – I want to **include**, at an additional cost, benefits for consultation, diagnosis and treatment of mental disorders including inpatient and outpatient services. I understand this election applies to all persons for whom application is being made. I also understand that this election may be made **only** at the time of this initial application. This election will be in force for the duration of my policy. Yes No

MEDICA DIRECT VALUE FOR INDIVIDUALS

1) Select your choice of the following policy year deductible.

- \$150 \$500 \$1,000 \$1,500 \$2,500 \$5,000

2) **Mental Health Coverage Election** – (Applies to plans with a deductible of \$1,000 or more. Mental Health coverage will be automatically included in Medica Direct Value for Individuals plans with a deductible of less than \$1,000). I want to **include**, at an additional cost, benefits for consultation, diagnosis and treatment of mental disorders including inpatient and outpatient services. I understand this election applies to all persons for whom application is being made. I also understand that this election may be made **only** at the time of this initial application. This election will be in force for the duration of my policy Yes No

3) **Chemical Dependency Coverage** – Chemical Dependency coverage is part of the benefit package and includes treatment or consultation for alcoholism, chemical dependency or drug addiction. I want to **decline** coverage for these benefits, which will result in a premium reduction. I understand that this applies to all persons for whom application is being made and may be made only at the time of initial application Yes No

Applicant's Name: _____

D. PAYMENT AND EFFECTIVE DATE SELECTION

- 1) Initial payment mode Check Credit Card Amount paid with this application \$ | | | | | . | | |
(Please make your check payable to Medica. Include the Credit Card Form if applicable.)
- 2) Ongoing payment mode *(check one)* Check Automatic Payment
(Include the ACH Authorization Form if applicable.)
- 3) **Effective Date:** Initial payment for this policy must be submitted with this application. We cannot process your application if you fail to answer all questions completely or if you fail to submit your initial payment.

MEDICA DIRECT HSA FOR INDIVIDUALS

I understand that, if approved by the last day of the month, coverage will be effective the first day of the following month. If possible, I would like my coverage to begin the first of the month of _____, provided this date is not more than 60 days beyond the signature date of this application. If this application is not approved, no Medica Direct HSA for Individuals coverage will be effective.

MEDICA DIRECT VALUE FOR INDIVIDUALS

I understand that, if approved by the last day of the month, coverage will be effective the first day of the following month. If possible, I would like my coverage to be begin the first of the month of _____, provided this date is not more than 60 days beyond the signature date of this application. If this application is not approved, no Medica Direct Value for Individuals coverage will be effective.

E. OTHER INSURANCE INFORMATION

- 1) Do you or any persons named on this application currently have **any** health coverage? Yes No
- 2) Have you ever been a member of Medica? Yes No
- 3) Have you or any persons named on this application had any health coverage within the past 63 days? Yes No

If "Yes" to any question, you must provide your health coverage history for the past 24 months and complete the insurance information below.

Person's name	Insurance company name	Effective date of coverage	Termination date of coverage	Reason for termination of health care coverage	Individual or group coverage or COBRA?

- 4) Were all persons named on this application covered under prior plan? Yes No
 If "No," list those not covered: _____
- 5) Will this coverage replace or change any existing health insurance? Yes No
 If "Yes," explain why: _____
- 6) Is any person named on this application covered by Medicare Part A and/or Part B? Yes No
- 7) Has any person named on this application applied for a Medica Direct for Individuals plan in the last 18 months? Yes No
 If "Yes," when? month | | | year | | | | Under what primary applicant name? _____

Applicant's Name: _____

F. HEALTH INFORMATION

Answer every question by checking a Yes or No box. Circle the medical condition(s) listed and complete Section F7 for all questions answered "Yes" for you and each person applying for coverage.

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

- | | Yes | No |
|---|--------------------------|--------------------------|
| a. Heart attack, coronary artery disease, heart bypass surgery, angioplasty, heart valve replacement or congestive heart failure? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Stroke, aneurysm, carotid artery blockage, blood clots, embolism or multiple sclerosis? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Emphysema, chronic obstructive pulmonary disease (COPD) or pulmonary fibrosis? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Hepatitis*, cirrhosis of the liver, pancreatitis, Crohn's disease or ulcerative colitis? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Diabetes? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Cancer? | <input type="checkbox"/> | <input type="checkbox"/> |
| g. HIV* positive, AIDS* or lupus? | <input type="checkbox"/> | <input type="checkbox"/> |

Section F2: Within the past five years, has any person named on this application been diagnosed with, treated for, or consulted with a physician or practitioner for:

- | | Yes | No |
|---|--------------------------|--------------------------|
| a. Heart disorders, including but not limited to chest pain, heart murmur, mitral valve prolapse, angina, high blood pressure or cardiovascular disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Circulatory or vascular disorders, including but not limited to peripheral vascular disease, varicose veins, varicose ulcer, blockage of arteries or other vascular or circulatory disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Respiratory disorders, including but not limited to shortness of breath, tuberculosis, asthma, allergies, hay fever, sleep apnea, pneumonia, or other lung disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Nervous system disorders, including but not limited to paralysis, epilepsy, fainting, dizziness, seizures, headaches, migraines, or any other disease or disorder of the brain or nervous system? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Digestive disorders, including but not limited to stomach or duodenal ulcer, other ulcer, hernia, gastroesophageal reflux disease (GERD), colitis, chronic diarrhea, jaundice, or any disorder of the liver, gallbladder, stomach, intestine, or rectum? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Urinary tract disorders, including but not limited to kidney, bladder, kidney and bladder stones, protein or blood in the urine, infection or other disorder(s) of the kidney(s), bladder, ureter(s), urethra, or prostate? | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Musculoskeletal disorders, including but not limited to arthritis or any disorder of the joints, muscles or bones, any knee, neck, back or spinal trouble, neuritis, sciatica, spinal curvature to include kyphosis and lordosis, fibromyalgia, gout, carpal tunnel syndrome, TMJ or amputation? | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Reproductive system disorders, including but not limited to any disease or disorder of the breast or reproductive organs (male and female), complication of breast implants, infertility, abnormal menstrual periods, endometriosis, or sexually transmitted disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Metabolic or endocrine disorders, including but not limited to sugar intolerance, albumin, blood or sugar in the urine, any disorder of metabolism or endocrine system? | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Eating disorders, including but not limited to anorexia, bulimia, unexplained weight loss or fever, obesity or other related disorders? | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Tumor, cysts, neoplasm or growths of any kind? | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Immune system disorders, including but not limited to collagen disease, scleroderma, rheumatoid arthritis or any other connective tissue disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| m. Blood disorders, including but not limited to anemia, hemophilia, hemochromatosis, leukemia or any other disease or disorder of the blood? | <input type="checkbox"/> | <input type="checkbox"/> |
| n. Any disease of the eyes, ears, nose, throat, tonsils, or sinuses? | <input type="checkbox"/> | <input type="checkbox"/> |
| o. Mental, emotional or nervous disorders, including but not limited to hyperactivity, attention deficit, anxiety, depression or personality disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| p. Glandular disorders, including but not limited to Addison disease, Cushing disease, goiter, lymph gland enlargement or any disease or disorder of the adrenal gland, thyroid gland, pituitary, pancreas, or lymph system? | <input type="checkbox"/> | <input type="checkbox"/> |
| q. Congenital birth or developmental disorders, including but not limited to cleft palate, club foot, congenital heart defects, chromosomal abnormalities, physical or cognitive delays or autism? | <input type="checkbox"/> | <input type="checkbox"/> |
| r. Skin disorders, acne, psoriasis, warts, lesions or any other disease or disorder of the skin? | <input type="checkbox"/> | <input type="checkbox"/> |
| s. General fatigue, malaise, mononucleosis, Chronic Fatigue Syndrome or Epstein-Barr Syndrome? | <input type="checkbox"/> | <input type="checkbox"/> |

* See page 2 for exceptions.

Applicant's Name: _____

F. HEALTH INFORMATION (continued)

Answer every question by checking a Yes or No box. Circle the medical condition(s) listed and complete Section F7 for all questions answered "Yes" for you and each person applying for coverage.

- Section F3: Within the past five years, has any person named on this application:** Yes No
- a. Been evaluated for or treated for alcoholism/chemical dependency; consumed alcohol to excess or used any controlled drug not prescribed by a doctor or exceeded prescription usage of any drug without physician approval?
 - b. Been convicted for or had a driver's license suspended for DWI/DUI or been convicted for any alcohol or drug-related moving violation?
 - c. Been advised by a medical professional to modify or restrict eating or drinking habits for health purposes?
 - d. Been hospitalized?
 - e. Been advised to have surgery, treatment or testing, not yet performed?
 - f. Participated in organized racing, including but not limited to automobile, motorcycle, or power boat racing or any of the following activities: skydiving, ultralight flying, scuba diving, hang gliding, rodeo participation, rock or mountain climbing?
 - g. Had an electrocardiogram, MRI, CT scan, echocardiogram, laboratory or diagnostic test or X-ray (other than dental)?
 - h. Been declined coverage, charged an increased rate, or had benefits excluded from coverage for any health care or life insurance coverage?
 - i. Had any medical treatment, or diagnosed or treated health impairment not already noted in this application?

- Section F4: Is any person or has any person named on this application:** Yes No
- a. An expectant father or expectant mother or anticipating the adoption of a child?
 - b. Expecting to become a parent through the use of assisted reproductive technologies such as infertility drugs or in-vitro fertilization?
 - c. Had any fixation/prosthetic device, including but not limited to, plates, screws, pins, implants, shunts, pacemakers, or valve replacement?
 - d. Currently disabled, hospitalized, on medical leave or receiving disability or workers' compensation benefits?
 - e. Used tobacco products during the 36 months immediately preceding the date of this application?
 - f. Within the last six months, been seen by a health professional for any medical treatment?

Section F5: Please list the date of last physical exam for all persons named on this application. Include blood pressure and cholesterol results, and all results of physical exam and diagnostic tests.

Person's name	Name and address of physician	
Date of exam	Type of exam	Results
Person's name	Name and address of physician	
Date of exam	Type of exam	Results
Person's name	Name and address of physician	
Date of exam	Type of exam	Results
Person's name	Name and address of physician	
Date of exam	Type of exam	Results
Person's name	Name and address of physician	
Date of exam	Type of exam	Results

Applicant's Name: _____

F. HEALTH INFORMATION (continued)

Section F6: Please list all medications taken for any persons named on this application in the past 12 months. Add additional page if you need more space.

Person's name	Drug name	mg/ml
Condition	Currently taking? <input type="checkbox"/> Yes : Dosage (how many taken each day): <input type="checkbox"/> No : Date (month/year) stopped:	
Person's name	Drug name	mg/ml
Condition	Currently taking? <input type="checkbox"/> Yes : Dosage (how many taken each day): <input type="checkbox"/> No : Date (month/year) stopped:	
Person's name	Drug name	mg/ml
Condition	Currently taking? <input type="checkbox"/> Yes : Dosage (how many taken each day): <input type="checkbox"/> No : Date (month/year) stopped:	
Person's name	Drug name	mg/ml
Condition	Currently taking? <input type="checkbox"/> Yes : Dosage (how many taken each day): <input type="checkbox"/> No : Date (month/year) stopped:	
Person's name	Drug name	mg/ml
Condition	Currently taking? <input type="checkbox"/> Yes : Dosage (how many taken each day): <input type="checkbox"/> No : Date (month/year) stopped:	
Person's name	Drug name	mg/ml
Condition	Currently taking? <input type="checkbox"/> Yes : Dosage (how many taken each day): <input type="checkbox"/> No : Date (month/year) stopped:	
Person's name	Drug name	mg/ml
Condition	Currently taking? <input type="checkbox"/> Yes : Dosage (how many taken each day): <input type="checkbox"/> No : Date (month/year) stopped:	
Person's name	Drug name	mg/ml
Condition	Currently taking? <input type="checkbox"/> Yes : Dosage (how many taken each day): <input type="checkbox"/> No : Date (month/year) stopped:	
Person's name	Drug name	mg/ml
Condition	Currently taking? <input type="checkbox"/> Yes : Dosage (how many taken each day): <input type="checkbox"/> No : Date (month/year) stopped:	
Person's name	Drug name	mg/ml
Condition	Currently taking? <input type="checkbox"/> Yes : Dosage (how many taken each day): <input type="checkbox"/> No : Date (month/year) stopped:	

Applicant's Name: _____

F. HEALTH INFORMATION (continued)

Section F7: If you have answered "Yes" to any questions in Sections F1 through F4, please complete this section. Give complete details. Add an additional page if you need more space.

Person's name		Diagnosis, treatment and results
Question No.	Days in hospital	
Date of onset	Date of complete recovery	Name and address of physician

Person's name		Diagnosis, treatment and results
Question No.	Days in hospital	
Date of onset	Date of complete recovery	Name and address of physician

Person's name		Diagnosis, treatment and results
Question No.	Days in hospital	
Date of onset	Date of complete recovery	Name and address of physician

Person's name		Diagnosis, treatment and results
Question No.	Days in hospital	
Date of onset	Date of complete recovery	Name and address of physician

Person's name		Diagnosis, treatment and results
Question No.	Days in hospital	
Date of onset	Date of complete recovery	Name and address of physician

Person's name		Diagnosis, treatment and results
Question No.	Days in hospital	
Date of onset	Date of complete recovery	Name and address of physician

Person's name		Diagnosis, treatment and results
Question No.	Days in hospital	
Date of onset	Date of complete recovery	Name and address of physician

Applicant's Name: _____

G. AUTHORIZATION & REPRESENTATION – Read this section, date and sign the application.

TO BE SIGNED BY APPLICANT:

I have reviewed the above statements/questions and the corresponding answers and declare them to be true and complete. I understand that this application form and any amendments will be the basis for my policy with Medica. Benefits under the policy, if approved, will be based upon the selection made in Section C, unless Medica has offered, and I have accepted, 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. If there is a misstatement in this application, Medica will not use a misstatement to rescind coverage that has been in effect for two (2) years starting from the effective date of coverage. This time limit does not apply to misstatements that are knowingly made on this application.

I understand and agree that my policy, if approved, will be issued solely as an individual/family policy and is offered pursuant to and in compliance with state and federal individual health plan laws. The policy is not offered pursuant to and does not comply with state or federal group health plan laws. I understand and agree that any attempt to use the individual policy in a manner that results in it being considered a group health plan under state or federal law is strictly prohibited.

If there is a change in my (or my spouse's or dependent's) health condition between the date of this application and my effective date of coverage, I agree to notify Medica immediately. This new information may be used in determination and/or reversal of my acceptance. If I do not notify Medica of any change in my (or my spouse's or dependent's) health condition prior to my effective date of coverage, my policy may be rescinded.

On behalf of myself and anyone enrolled on or added to this application ("Us"), I authorize any hospital, clinic, institution, physician, insurance company, MIB, Inc. ("MIB"), or other organization, institution or person to give Medica or any of its designees any and all records or information pertaining to medical history or services rendered to Us. I understand that this information will be used for underwriting, risk rating, enrollment or eligibility for benefits. I understand that in certain circumstances Medica may disclose the information collected to third parties without authorization and that the individuals enrolled on or added to this application have the right to see and correct their personal information in accordance with applicable law. I understand that I have the right to review Medica's Privacy Notice before signing this form and to request a copy at any time. This authorization does not extend to a release concerning the performance of, or results of, a test to determine the presence of the HIV antibody or other blood borne pathogen for persons as described on page 2 of this enrollment form. I also authorize on behalf of Us the use of a Social Security Number for the purpose of identification. The information provided on this application is accurate and complete. I understand and agree that any omissions or incorrect statements knowingly made by Us on this application may invalidate my or my dependent's coverage. I understand that I may revoke this authorization by notifying Medica in writing. If I revoke the authorization, it will not affect any actions already taken by Medica prior to Medica's receipt of the revocation. If I refuse to sign this authorization, it will affect my and my dependent's eligibility and enrollment for benefits. Unless revoked, this authorization will remain in effect until termination of coverage. Information used or disclosed pursuant to this authorization will remain subject to Medica's privacy standards. A photographic copy of this authorization shall be as valid as the original.

I understand if I am approved for coverage, my policy will not cover preexisting conditions during the first 18 months following my enrollment date. However, if I have maintained continuous health care coverage, the preexisting condition limitation applies during the first 12 months following the enrollment, and will be reduced by the aggregate of certain periods of qualifying coverage applicable to me as of the enrollment date.

As a spouse or dependent named on this application, I authorize Medica to disclose my protected health information to the Applicant if such information is the basis for Medica's denial of coverage.

I know that my application contains personal information, including health care information, about me (and my dependents). By checking "Yes" in the space provided, I will be releasing my application to both Medica and my broker of record, who will have access to my personal information. By checking "No" in the space provided, I will be releasing my application only to Medica. My broker of record will not receive my application or have access to my personal information. My choice will not affect my eligibility for the policy I am applying for. Yes No

X

Signature of Applicant Date

X

Signature of Spouse or Other Insured Date
(If proposed to be insured)

X

Signature(s) of Other Dependents 18 or Over Date
(If proposed to be insured)

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

Applicant's Name: _____

H. FOR AGENT USE ONLY

Application was completed by

- applicant**
- agent**

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.

Agent's Signature X		Date
Print Agent's Name Ron Grams Jr.	Agent's Number #7284	Agent's Telephone Number (763) 550-0638

Please write legibly for this to be processed.

I. FOR OFFICE USE ONLY

Date Received	Eff. Date of Policy	Plan Code	PE Mo. A. B. C. D. E.					
Reviewed by:	Date:	A D	Payment ID	Amount				

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.

MEDICA®

**Mail Route CP320
PO Box 9310, Minneapolis, MN 55440-9310**

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Medica Direct for IndividualsSM is a service mark of Medica.

CHA2629-10608

Automated Payment Plan (ACH)

Here's How You Benefit From Automatic Premium Payment:


Peace of Mind – have peace of mind that your Medica coverage continues because your health plan premium is paid on time, every time.

Easy – no more wondering if you have envelopes, stamps or checks on hand.

Safe – Automatic premium payment is a safe transaction, protecting you and your hard-earned money. Should there ever be a dispute about a fund transfer, electronic records make it easier to resolve the issue. The fund transfer is conducted using the Automated Clearing House (ACH) system with the withdrawal happening up to the 4th of the month. ACH is a fund transfer system with national rules, standards and procedures that allows financial institutions to make electronic payments on behalf of its customers. ACH is widely used by financial institutions across the country.

Here's What You Need To Do:

- **Complete the Authorization Form below. For additional assistance in identifying your account routing number, please see the check graphic on reverse.**
- **If you are mailing this Authorization Form along with an application for coverage, please be sure you include a check for one month's payment.**
- **If you are already a Medica Direct Value or HSA member, do not send money. However, in order for the ACH program to be activated by the time your next premium is due, Medica must receive the attached Authorization Form at least 30 days prior to the start of the month you would like it effective. Mail the completed form to the address listed at the bottom of the Authorization Form below.**

 Please cut along dotted line to detach Authorization Form.

Automated Payment Plan (ACH) Authorization Form

Name on bank account:

Bank account number:

Account routing number (found along bottom of check):

Bank name:

Telephone:

City:

State:

Zip code:

I authorize Medica and the bank named above to initiate monthly withdrawals from my checking or savings account, as indicated. This agreement will remain in effect until I notify Medica and my bank in writing to cancel it.

Print name of applicant:

Social Security No.:

Date:

Signature of bank account holder

Date:

Signature of bank account holder (if joint account)

Please mail this completed ACH Authorization Form to:

Medica Automated Payment Plan
Attn: Individual Administration Route MN015-2838
4316 Rice Lake Road
Duluth, MN 55811

Or, fax it to: 218-279-6493