



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

A. APPLICANT INFORMATION

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) If applicant is a minor child, please list parent(s) or legal guardian(s)						
4) Applicant's home address		<i>Street</i>	<i>City</i>	<i>State</i>	<i>ZIP</i>	<i>County</i>
5) Billing address (<i>if different from #4</i>)		<i>Street</i>	<i>City</i>	<i>State</i>	<i>ZIP</i>	<i>County</i>
6) E-mail address		7) Home telephone no. ()		8) Cellular telephone no. ()		Best time to call: ___ A.M. ___ P.M.
9) Please indicate your current eligibility status: <input type="checkbox"/> I was born in the United States <input type="checkbox"/> I am a legal U.S. citizen under Naturalization <input type="checkbox"/> I have been a permanent U.S. citizen for at least one year (with a Green Card) <input type="checkbox"/> Other:						
10) Are you a permanent resident of Minnesota currently residing in Minnesota? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," please explain:						
11) Occupation			Company name			
Self employed? <input type="checkbox"/> Yes <input type="checkbox"/> No		Work telephone no. ()		Hours worked per week _____ <input type="checkbox"/> Full time <input type="checkbox"/> Part time		Covered by Worker's Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No
Duties		12) Social Security Number		13) Birth date (<i>mo/day/yr</i>)		14) State of birth
		15) Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		16) Height ft. in.		17) Present weight lbs.
19) Reason for application (<i>check one</i>): <input type="checkbox"/> I am a new applicant presently not covered under a Medica policy. <input type="checkbox"/> I presently have Medica coverage. I am covered under I.D. number:						

B. BENEFIT SELECTION (select either Solo or Encore and complete the correct section)

- Medica Solo**SM
 - 1) Select your choice of the following plans
 - 100% Plan
 - \$3,100 Deductible Coverage
 - \$6,200 Deductible Coverage
 - \$9,300 Deductible Coverage

- Medica Encore**SM
 - 1) Select your choice of the following plans
 - 100% Plan
 - \$4,000 Deductible Coverage
 - \$6,500 Deductible Coverage
 - \$9,000 Deductible Coverage

Applicant's Name: _____

E. YOUR HEALTH INFORMATION

Answer every question by checking a Yes or No box. For each question answered "Yes," please complete Section E7.

SECTION E1: 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 E2: Within the past five years, have you been diagnosed with, or treated for, or consulted with a physician or practitioner for:

- | | | |
|--|--------------------------|--------------------------|
| 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, lung or respiratory 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"/> |

SECTION E3: Within the past five years, have you:

- | | | |
|---|--------------------------|--------------------------|
| a. Been evaluated for, treated for, or joined any organization for alcoholism/chemical dependency (you are not required to disclose the name of the organization); consumed alcohol to excess or used any controlled drug not prescribed by a doctor or exceeded prescription usage of any drug without physician approval? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Been advised by a medical professional to modify or restrict eating or drinking habits for health purposes? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Been hospitalized? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Been advised by a medical professional to have surgery, treatment or testing, not yet performed? | <input type="checkbox"/> | <input type="checkbox"/> |

Continues next page >

* See page 2 for exceptions.

Applicant's Name: _____

F. AUTHORIZATION & REPRESENTATION – Read this section, then sign and date 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 B, unless Medica has offered, and I have accepted, an alternative plan. I understand that if I do not qualify for the coverage selected, Medica may offer an alternative plan. Medica will not rescind coverage that has been in effect for two (2) or more years UNLESS I knowingly made a misstatement on this application form.

I understand and agree that my policy, if approved, will be issued solely as an individual policy. 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 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 health condition prior to my effective date of coverage, my policy may be rescinded.

On behalf of myself, 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 me. 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 I have the right to see and correct my 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 as described on page 2 of this enrollment form. I also authorize 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 me on this application may invalidate my 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 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. I authorize Medica to disclose my protected health information to the Guarantor identified below if I am under age 18 and if such information is the basis for Medica's denial of coverage.

I know that my application contains personal information, including my health care information. 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 Guarantor, Parent or Legal Guardian Date
(Please complete if the Applicant is under age 18)

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.

G. FOR AGENT USE ONLY

Application was completed by Applicant (Parent or Legal Guardian if applicant is under age 18) 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. *Please write legibly for this to be processed.*

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

H. FOR OFFICE USE ONLY

Date Received	Policy Effective Date	Plan Code	PE Mo.	Reviewed By:	Payment ID	Amount
				Date: A D		

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 SoloSM and Medica EncoreSM are service marks of Medica Health Plans.

CHA4806-11008

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.:

X

Date:

Signature of bank account holder

X

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