

**MEDICA<sup>®</sup>**

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MINNESOTA

**Medica Direct  
Short-Term<sup>SM</sup>  
for Individuals**

*Application Form.....*



**E. 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. The policy, if approved, will be based upon the information supplied in Section C.

I understand and agree that my policy, if approved, will be issued solely as an individual/family 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 (or my spouse's or dependent's) eligibility 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any change in my (or my spouse's or dependent's) eligibility prior to my effective date of coverage, my policy may be rescinded.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, or other 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 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. 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. Information used or disclosed pursuant to this authorization will remain subject to Medica's privacy standards. Unless revoked, this authorization will remain in effect until termination of coverage.

I understand that I am not required to disclose the results of a test to determine the presence of the human immunodeficiency virus (HIV) antibody performed on a criminal sex offender or a crime victim who was exposed to or had contact with an offender's bodily fluids during commission of a crime that was reported to law enforcement. Additionally, I am not required to disclose the results of a test to determine the presence of a bloodborne pathogen performed on the following individuals when a significant exposure may have occurred: (1) an emergency medical services person or source individual at a hospital or freestanding emergency medical care facility; or (2) a corrections employee or source inmate at a correctional facility; or (3) an employee of a secure treatment facility or source patient at a secure treatment facility.

The term "emergency medical services persons" includes (1) individuals employed or receiving compensation to provide out-of-hospital emergency medical services such as a firefighter, paramedic, emergency medical technician, licensed nurse, rescue squad person, or other individual who serves as an employee or volunteer of an ambulance service as defined by Minnesota law or a member of an organized first responder squad that is formally recognized by a political subdivision in the state, who provides out-of-hospital emergency medical services during the performance of the individual's duties; (2) an individual employed as a licensed peace officer under Minnesota law; (3) an individual employed as a crime laboratory worker while working outside the laboratory and involved in a criminal investigation; (4) any individual who renders emergency care or assistance at the scene of an emergency or while an injured person is being transported to receive medical care and who is acting as a good samaritan as described under Minnesota law; and (5) any individual who, in the process of executing a citizen's arrest as defined by Minnesota law, may have experienced a significant exposure to a source individual.

I declare that I understand coverage is limited. I understand that the Medica Direct Short-Term for Individuals policy does not cover preexisting conditions for the entire term of the policy. A preexisting condition is any injury, illness, or condition for which the covered person had medical treatment, symptoms, or any manifestations before the effective date of the policy.

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

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

**F. AGENTS**

Application was completed by  applicant  agent. I certify that I have reviewed this application. If this 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.

X Agent's Signature	Print Agent's Name & Number	( ) Agent's Phone Number	Date
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**G. FOR OFFICE USE ONLY**

Date Received	Plan Code	Effective Date	Term Date	Payment ID	Amount
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*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.*

## **Medica Privacy Notice**

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

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

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

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

# **MEDICA<sup>®</sup>**

**Mail Route CP320**

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