



Since 1976

Minnesota Comprehensive Health Association Instructions & Application for Basic Medicare Supplement Plan

www.mchamn.com

MCHA Medicare Sales

952-992-2345 or 1-800-906-5432

TTY: Call the National Relay Center at 1-800-855-2880 and ask for 1-800-906-5432

Monday – Friday: 8 a.m. – 5 p.m. CST

MCHA Customer Service

952-992-2443 or 1-800-325-3540

TTY: Call the National Relay Center at 1-800-855-2880 and ask for 1-800-325-3540

Monday – Friday: 8 a.m. – 5 p.m. CST

Saturday: 9 a.m. – 5 p.m. CST

MCHA Broker / Agent Service Center

952-992-2200 or toll-free at 1-800-936-6880

Monday – Friday: 8 a.m. – 5 p.m. CST

Review the “Instructions for Application” before completing the application.

Mail the completed application and applicable premium to:

Minnesota Comprehensive Health Association/Medica

Mail Route CW 282

401 Carlson Parkway

Minnetonka, MN 55305-5387

Failure to completely answer all questions and to submit required documentation may delay the processing of your application or the date your coverage becomes effective. Your payment must accompany this application.

This is an application for coverage only. The benefits provided by MCHA, as well as the terms, conditions, limitations, and exclusions governing those benefits are contained in the MCHA Policy of Coverage and Minnesota law. This application for individual coverage in no way binds MCHA to provide specific benefits to you, nor does it control the terms, conditions, limitations, or exclusions of benefits if coverage is offered to you.



This Plan is generally not available to Medicare beneficiaries who are in their initial eligibility period (first six months of Medicare eligibility).

The MCHA Basic Medicare Supplement Plan is intended for Medicare beneficiaries who cannot get coverage in the private market.

Instructions for Application

This application contains Sections A-M. **You must complete all sections identified on the application as “Required Information.”** Incomplete applications will be returned to you for completion and may delay your effective date of coverage. Some areas of the application require you to initial the section, providing proof you have read the information and have provided accurate information.

If you have questions about MCHA, eligibility, health plan options and services available to you, call the MCHA Medicare Sales telephone number listed on the front cover of this application or refer to the “MCHA Disclosure Information and Summary of Benefits for the Basic Medicare Supplement Plan” brochure.

The following information corresponds with each section on the application.

Section A. Plan Option *(Required Information)*

Basic Medicare Supplement Plan

- I am age 65 or over
- I am under age 65

Select any of the optional riders for the Basic Medicare Supplement Plan:

- Coverage for all of the Medicare Part A inpatient hospital deductible.
- Coverage for all of the Medicare Part B annual deductible.
- Coverage for 100% of the charges that exceed the Medicare approved amount for Part B covered services and supplies.
- Coverage for up to \$120.00 per calendar year for certain preventive medical care services that are not covered by Medicare.

NOTE: This policy does not provide benefits for expenses incurred during the first 6 months of coverage for treatment of an injury, illness, or other physical or mental condition if that injury, illness or condition was diagnosed or treated during the 90-day period immediately prior to the date MCHA received the cover person’s application. “Treatment” means the management and care of a patient for the purpose of combatting that condition. “Treatment” includes medical and surgical care, diagnostic evaluation, giving medical advice, monitoring and the prescribing and/or taking of prescription medications for that condition. This preexisting condition limitation shall not apply to expenses incurred after the first 6 consecutive months of coverage under the policy. **The preexisting condition limitation is waived if the policy becomes effective within 6 (six) months after your Federal Medicare Part B effective date. If the policy is replacing another Medicare Supplement policy, the preexisting condition limitation period will be waived to the extent of time spent under the prior policy.**

Section B. Applicant Information *(Required Information)*

The applicant is the individual applying for MCHA coverage. The applicant must be enrolled in both Medicare Part A and Medicare Part B to be eligible for MCHA’s Medicare Supplement Plan.

Section C. Residency *(Required Information)*

You (the applicant) must be a resident of the State of Minnesota. You must provide proof of Minnesota residency for at least six (6) months prior to the date you are making application to MCHA.

Documents must include the name of the applicant and current Minnesota mailing address, and must be dated within the last six (6) months.

Required Documentation- Acceptable documents proving Minnesota residency include:

- A copy of your current driver’s license
- Current Minnesota State ID with an issue date within the past 4 years
- A current (within the last six 6 months) utility bill
- A recent voter registration card (if registration occurred within last 6 months)

MCHA reserves the right to rely upon other documentation, in its discretion, to determine if an applicant satisfies the residency requirement.

Section D. Tobacco Designation

(Required Information)

MCHA has “Standard” (non-Tobacco User) premium rates and “Tobacco User” premium rates. You must identify if you have used tobacco, including: smoking cigarettes, cigars, pipe, use chewing tobacco, snuff or have used nicotine chewing gum, the nicotine patch or other prescription or over the counter smoking cessation products within the 12 months immediately preceding the date of the application. You must pay the appropriate premium rate that corresponds to your tobacco-user designation.

Section E. Employment Status *(Required Information)*

You are required to identify your employment status

You are **not eligible** for MCHA coverage if you are an employee and eligible for an employer’s health plan. Minnesota law prohibits employers from directing an employee to apply for MCHA if they are eligible for the employer’s health care plan. Identified cases are reported to the Minnesota Department of Commerce for appropriate action.

Section F. Other Health Coverage Information

(Required Information)

You are required to provide information on your prior health insurance coverage. You are also required to identify other health insurance coverage you have currently.

Note: MCHA can only issue this policy if you are **enrolled** in both Medicare Part A and Medicare Part B.

Section G. Reason for Applying for MCHA

(Required Information)

Identify the reason(s) you are applying for MCHA coverage. This information is kept confidential and is not used to determine eligibility.

Section H. Eligibility *(Required Information)*

There are two (2) different eligibility categories by which you can apply for MCHA coverage. Review the eligibility categories **and choose only one (1)**. Check the appropriate boxes, and include required documentation.

Eligibility:

1. Health Related Rejection: Eligibility under this category is determined by whether you have a health related condition that prevents you from being accepted for individual insurance coverage with another insurance carrier. You must have received a rejection of coverage due to a health condition(s) within the last six (6) months, from a:

- a) Minnesota health insurance carrier; or
- b) Minnesota licensed insurance agent (the agent must complete the “*Agent Certification of Eligibility*” information within section “L. Agent Information”).

If you are eligible under this category, the effective date of coverage is the date the application and all required documentation and premium is received by MCHA, or if a preexisting condition limitation waiver is requested and approved, the effective date will be backdated to the day following termination of prior coverage. If you choose a date other than the day after termination of prior coverage, the waiver is relinquished and a six-month pre-existing condition limitation will apply to your policy. Refer to the application section “I. Request for Pre-existing Condition Limitation Waiver.”

2. Presumptive Condition(s): If you have been treated for one of the presumptive conditions listed within the application, under section “H. Presumptive Condition(s)” (application page 9) within the last 3 years, you are eligible for MCHA coverage. Your physician must complete the “Physician’s Statement” (application page 9) certifying eligibility and identifying you as having one of the recognized conditions or diagnoses.

If you are eligible under this category, the effective date of coverage is the date the application and all required documentation and premium is received by MCHA, or if a preexisting condition limitation waiver is requested and approved, the effective date will be backdated to the day following termination of prior coverage. If you choose a date other than the day after termination of prior coverage, the waiver is relinquished and a six-month pre-existing condition limitation will apply to your policy. Refer to the application section “I. Request for Pre-existing Condition Limitation Waiver.”

Section I. Request for Pre-existing Condition Limitation Waiver [Required information only if you are requesting a waiver.]

If applying for coverage under option 1 or option 2 above, you are subject to a Pre-existing Condition Limitation. This means that your MCHA policy will not provide benefits for medical expenses incurred during the first six (6) months of coverage for treatment of an injury, illness, or other physical or mental condition (including the provision of prenatal care and maternity related services) if that injury, illness, or condition was diagnosed, treated, or evaluated during the 90-day period immediately prior to the effective date (including treatment with prescription drugs).

Under certain situations you may be eligible for a waiver of the pre-existing condition limitation. This section allows you to apply for a waiver. To be eligible for a waiver you must apply for MCHA coverage within 90 days of termination of your prior coverage and provide the required documentation for review. Application for a waiver does not guarantee the waiver of the pre-existing condition limitation. You will be notified by mail if you have been accepted for coverage, but are not eligible for a waiver of the pre-existing condition limitation.

If you are approved for a waiver of the pre-existing condition limitation, your effective date of coverage will be retroactive to the day after the cancellation date of your previous health coverage. If your pre-existing condition limitation waiver is approved, and you choose to have a different effective date other than the day after the cancellation date of your previous health coverage, you relinquish the waiver of the pre-existing condition limitation (meaning a six-month pre-existing condition limitation will apply to your policy).

Section J. Applicant’s Disclosure Authorization and Declaration (Required Information)

You must initial each section and sign/date the **bold** statement confirming you have read the information.

“Future Effective Date”: You may request a *future* effective date for your MCHA coverage if you choose a date other than the day the completed application is received by MCHA. Indicate in this section the future date you wish coverage to go into effect. If you are eligible for a pre-existing condition limitation waiver (section “I. Request for Pre-existing Condition Limitation Waiver”), you cannot choose a future effective date and maintain the waiver. Retroactive effective dates cannot be considered unless you apply for and receive approval for a waiver of the pre-existing condition limitation (i.e. retroactive effective date adjusted if a prior coverage annual or lifetime benefit maximum is reached).

Section K. Premium Payment Options (Required Information)

You must indicate how you want to pay your premiums. You have two options:

- Monthly payments: For monthly payments, you are required to utilize the Automatic Clearing House (ACH) process. This is an automatic payment process that will deduct the premium payment from your designated checking or savings account. This withdrawal usually occurs about the 5th day of each month.
- Quarterly payments: Quarterly payments are for each calendar quarter (January-March, April-June, July-September, and October-December) and can be made through the ACH deduction process or by receiving a premium statement and mailing in your payment. Premium payments are due the first day of each calendar quarter (January 1st, April 1st, July 1st and October 1st).

For the monthly or quarterly ACH process, complete the “ACH Authorization Agreement.” Attach a voided check or savings account deposit slip to the bottom of page 12 of the application. **A checking account deposit slip is not acceptable.** If ACH premiums will be paid by checking account and voided check is not attached, MCHA will use the submitted premium check account number to set up the ACH process.

You will receive your MCHA premium notice around the 20th day of the month prior to the payment due date.

Whether you choose the monthly or quarterly premium payment option, remember to **include your first premium payment with this application.** Failure to include the proper premium payment will delay the

processing of your application and potentially the effective date of coverage.

Each MCHA policyholder is responsible to make premium payments on behalf of themselves.

Section L Agent Information

If you choose to have assistance from a Minnesota licensed health insurance agent in completing and submitting your MCHA application, the agent will receive a one (1) time \$50 referral fee from MCHA upon acceptance of the application and receipt of the first MCHA premium payment.

Agent Certification of Health Related Rejection:

If an agent is certifying your eligibility under section "H. Eligibility" option number 1 (Health related Rejection) the agent must fully complete, sign and date this section.

Section M. Check List

Review the checklist to help assure all necessary information and documentation is included with your application. Incomplete applications and missing documentation will delay the processing of your application and may possibly affect your effective date of coverage.

IMPORTANT INFORMATION:

Mail the completed application, required documentation and applicable premium to:

Minnesota Comprehensive Health Association
Medica
Mail Route CW 282
401 Carlson Parkway
Minnetonka, MN 55305-5387

- ✓ Your first monthly or quarterly premium payment must accompany this application. Refer to the "MCHA Standard/Tobacco-User Premium Rates" sheet to determine the appropriate premium due.
- ✓ Failure to completely answer all required information and failure to submit all required documentation may delay the processing of your application and the effective date of coverage.
- ✓ MCHA has 30 days to process your application from the date the completed application, with the required documentation, is received.

E. Employment Status: *Required Information*

You are not eligible for MCHA if your employer offers health coverage to its employees. Minnesota law prohibits employers from encouraging or directing an employee or applicant to apply for MCHA coverage if they are eligible for the employer group plan coverage. Identified cases are reported to the Minnesota Department of Commerce for appropriate action.

Complete the following section:

1. Are you a dependent of an employed person? Yes No

2. What is your employment status, or the employment status of your parent/ legal guardian (if you are under age 19) or spouse:
Employed full-time: Yes No Employed part-time: Yes No Self-employed: Yes No Unemployed: Yes No

3. What is the occupation of employed person: _____

a. Identify the name, address, and phone number of the employer or the employed person.

Name: _____ Telephone number: _____

Address: _____

b. Does the employer currently employ 51 or more employees? Yes No

c. Does the employer offer health coverage to its employees? Yes No

d. Does the employer offer health coverage to the dependents of the employees? Yes No

e. If health coverage is offered, is coverage available through a group policy or an individual plan? Group Individual

f. Are you covered under the employer’s health plan? Yes No If “No”, please explain why: _____

g. Is the dependent covered under the employer’s health plan? Yes No If “No”, please explain why: _____

h. If you are covered under the employer’s health plan, do you have a pre-existing condition limitation period on your policy?

Yes No If “Yes,” identify when the pre-existing condition limitation will expire: _____

i. If you are covered under the employer’s health plan, do you have a dollar or benefit limitation that has been exceeded?

Yes No If “Yes,” identify the dollar limit or benefit limitation that has been exceeded and provide documentation from the current health carrier or the employer verifying this information: Dollar limitation (annual or lifetime limit): _____

Benefit limitation (identify the benefit and the limitation): _____

F. Other Health Coverage Information: *Required Information*

MCHA can only issue this policy if you are enrolled in both Medicare Part A and Medicare Part B. You do not need more than one Medicare supplement policy or certificate. If you purchase the policy, you may want to evaluate your existing health coverage and decide if you need multiple coverage. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy or certificate. The benefits and premiums under the Medicare supplement policy can be suspended, if requested, for up to 24 months during your entitlement to benefits under Medicaid. You must request this suspension within 90 days of becoming eligible for Medicaid. The policy will be reinstated if requested within 90 days of losing Medicaid eligibility. Counseling services may be available in Minnesota to provide advice concerning medical assistance through state Medicaid, Qualified Medicare Beneficiaries (QMBs), and Specified Low-Income Medicare Beneficiaries (SLMBs).

Are you covered by:

1. Medical Assistance or TEFRA (Tax Equity and Fiscal Responsibility Act)? Yes No

If “Yes”, identify who is covered: _____

2. General Assistance? Yes No If “Yes”, identify who is covered: _____

3. Minnesota Care? Yes No If “Yes”, identify who is covered: _____

4. Medicare? Yes No If “Yes”, identify who is covered and complete a.-d. below:

a. Effective date of Hospital Insurance (Medicare Part A) _____

b. Effective date of Medical Insurance (Medicare Part B) _____

c. Your Medicare number _____

5. Any other current health coverage? Yes No If “Yes,” who is covered? _____

If “Yes,” identify the type of policy: Employer group policy Individual plan policy

6. Identify your current or most recent health insurance carrier: Current health carrier Previous health carrier

a. Name of health insurance carrier:	b. Dates of coverage: From: _____ To: _____
c. Name of policyholder:	d. Phone number of health insurance carrier:
e. Identification number of coverage:	f. Group number (if any):
g. Name of employer providing coverage:	h. Phone number of employer providing coverage:

G. Reason for Applying for MCHA: *Required Information*

1. I am unable to obtain individual coverage because of a health related condition. Yes No

If "Yes" check the box identifying the health condition that prevents you from obtaining coverage. (*This information is confidential and is not be used to determine eligibility.*)

- | | | |
|---|---|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Confidential per previous insurer | <input type="checkbox"/> Joint disorder |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Endocrine disorder (i.e. diabetes) | <input type="checkbox"/> Liver disorder |
| <input type="checkbox"/> Arthritis/osteoporosis | <input type="checkbox"/> Eye/ear condition | <input type="checkbox"/> Mental health condition |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gastrointestinal condition | <input type="checkbox"/> Muscular condition |
| <input type="checkbox"/> Back/neck condition | <input type="checkbox"/> Gynecological/genitourinary | <input type="checkbox"/> Neurological disorder |
| <input type="checkbox"/> Blood disorder | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Breast disease | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Respiratory disorder |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High cost of medications | <input type="checkbox"/> Skin disorder |
| <input type="checkbox"/> Cardiovascular condition | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Weight condition |
| <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> Kidney disorder | <input type="checkbox"/> Other (please identify condition): _____ |

2. Check the one (1) reason that best describes why you are applying for MCHA coverage:

- MCHA premium rates were less than premium rates quoted to me for a comparable policy in the private market.
- I was unable to afford or to continue to afford my premium rates for COBRA or other continuation coverage under similar state law.
- I have exhausted my lifetime benefits under my current employer policy. Employer name: _____
- I have exhausted my annual benefits under my current employer policy. Employer name: _____
- My employer sponsored retiree plan was cancelled, benefits reduced or premiums became unaffordable. Employer name: _____
- I was not eligible for group coverage or was unable to continue my health coverage because no continuation was available. Employer name: _____
- My employer went bankrupt or went out of business. Employer name: _____
- My employer laid me off without the option for continued coverage. Employer name: _____
- My employer cancelled its group coverage. Employer name: _____
- My insurance company cancelled my individual Medicare supplement policy or my employer's group policy.

H. Eligibility: *Required Information*

Review the eligibility options on the next page **and choose ONLY one (1)**. Check the appropriate box and include the required documentation.

Eligibility– Generally, a six (6) month pre-existing condition limitation applies to these eligibility categories. However, to request a waiver of the pre-existing condition limitation, refer to section "I. Request for Pre-existing Condition Limitation Waiver" on page 10 of the application. The effective date of coverage is the date MCHA receives all necessary information to process the application, unless a waiver is granted or a future effective date is requested (refer to instructions).

1. Health Related Rejection

Check the statement that applies.

- a) I have received, within the last six (6) months, a rejection or notice of benefit reduction from a health insurance carrier for individual Medicare insurance coverage due to health related reasons. **You MUST submit a dated copy of the insurance carrier denial letter including the name of the health insurance carrier, along with documentation listing the medical or health related reason for the denial.**
- b) I have received a rejection of individual Medicare insurance coverage due to a medical or health related reason(s) from a Minnesota licensed insurance agent. **A Minnesota licensed insurance agent MUST complete section “L. Agent Information - Agent Certification of Health Related Rejection” of this application (Refer to page 13 of the application).**

2. Presumptive Condition(s)

- My health status disqualifies me from coverage in the private market, and I have been treated for one of the medical conditions listed below within the last 3 years.

Your physician must complete the “Physician’s Statement” certifying eligibility and identifying you have one of the MCHA presumptive conditions or diagnoses listed below:

Physician’s Statement

Identify presumptive condition from the list below and last date(s) of treatment: Applicant **MUST** have been treated within the last 3 years.

Physician’s Name (please print)	Physician’s License Number	Physician’s Signature	Date

MCHA Presumptive Conditions

<ul style="list-style-type: none"> <input type="checkbox"/> AIDS/HIV <input type="checkbox"/> Alzheimer’s Disease <input type="checkbox"/> Amyotrophic Lateral Sclerosis (ALS) <input type="checkbox"/> Angina Pectoris <input type="checkbox"/> Anorexia Nervosa or Bulimia <input type="checkbox"/> Aortic Aneurysm <input type="checkbox"/> Ascites <input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Chronic Pancreatitis <input type="checkbox"/> Chronic Renal Failure <input type="checkbox"/> Cirrhosis of Liver <input type="checkbox"/> Coronary Insufficiency <input type="checkbox"/> Coronary Occlusion <input type="checkbox"/> Crohn’s Disease (Regional Enteritis) <input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> Dermatomyositis <input type="checkbox"/> Friedreich’s Ataxia <input type="checkbox"/> Hemophilia <input type="checkbox"/> Hepatitis C <input type="checkbox"/> History of Major Organ Transplant <input type="checkbox"/> Huntington Chorea <input type="checkbox"/> Hydrocephalus <input type="checkbox"/> Insulin Dependent Diabetes 	<ul style="list-style-type: none"> <input type="checkbox"/> Leukemia <input type="checkbox"/> Malignant Lymphoma <input type="checkbox"/> Malignant Tumors <input type="checkbox"/> Metastatic Cancer <input type="checkbox"/> Motor/Sensory Aphasia <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Myasthenia Gravis <input type="checkbox"/> Myocardial Infarction <input type="checkbox"/> Myotonia <input type="checkbox"/> Open Heart Surgery <input type="checkbox"/> Paraplegia <input type="checkbox"/> Parkinson’s Disease <input type="checkbox"/> Polyarteritis Nodosa <input type="checkbox"/> Polycystic Kidney <input type="checkbox"/> Primary Cardiomyopathy <input type="checkbox"/> Progressive Systemic Sclerosis (Scleroderma) <input type="checkbox"/> Psychotic Disorder <input type="checkbox"/> Quadriplegia <input type="checkbox"/> Stroke <input type="checkbox"/> Syringomyelia <input type="checkbox"/> Systemic Lupus Erythematosus (SLE) <input type="checkbox"/> Wilson’s Disease
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I. Request for Pre-existing Condition Limitation Waiver:

Required information when requesting a waiver. Complete this section based on your current or most recent health insurance carrier. If a pre-existing condition limitation waiver is requested and approved, the effective date will be backdated to the day following termination of prior coverage.

- To be eligible for a waiver of the pre-existing condition limitation, you must apply for MCHA coverage within 90 days of the termination date of your prior coverage.
 - Check one box below.
 - Completion of this information does not guarantee a waiver of the pre-existing condition limitation. You will be notified by mail of the status of your waiver request.
1. My employer terminated coverage without offering continuation coverage. Provide documentation from your past employer or health insurance carrier identifying the cancellation date and the reason coverage was terminated.
2. I have exhausted my continuation coverage under COBRA or other continuation coverage under a similar state law. Provide documentation from your past employer or health insurance carrier stating you have exhausted your continuation rights. Identify the effective date and cancellation date of your prior coverage and current paid-to-date of your continuation policy.
3. I was unable to afford or continue to afford my premiums for COBRA or other continuation coverage under a similar state law. Provide documentation from your past employer or health insurance carrier identifying the cancellation date and provide documentation of your COBRA/continuation premium rates.
4. I was terminated or laid off (voluntarily or involuntarily) from employment and I am unable to exercise my option to continue my group coverage. Provide documentation from your past employer identifying the cancellation date and the reason continuation coverage was not available.
5. I was covered by an employer retiree plan and the coverage is no longer available. Provide documentation from your past employer identifying the cancellation date and reason coverage was terminated.
6. My previous coverage was provided by a rehabilitation facility and coverage was terminated. Provide documentation from rehabilitation facility identifying the cancellation date and reason the coverage was terminated.
7. I was covered under a conversion policy and I cancelled the coverage. Provide documentation from your previous health insurance carrier confirming your previous coverage was a conversion policy and the cancellation date.
8. My health insurance carrier terminated my group health insurance coverage. My coverage was not terminated because I failed to pay premiums, or because I voluntarily terminated coverage, or because I provided materially false statements or misrepresented myself in my terminated policy application. Provide documentation from your previous health insurance carrier identifying the cancellation date and the reason coverage was terminated.
9. My health insurance carrier terminated my individual health insurance coverage. My coverage was not terminated because I failed to pay premiums, or because I voluntarily terminated coverage, or because I provided materially false statements or misrepresented myself in my terminated policy application. Provide documentation from your previous health insurance carrier identifying the cancellation date and reason the coverage was terminated.
10. My previous coverage ended due to insolvency of the health insurance carrier. Provide documentation from your previous health insurance carrier identifying the date your benefits were exhausted.
11. I have exceeded the lifetime maximum benefit under my previous coverage. Provide documentation from your previous health insurance carrier identifying the date your benefits were exhausted.
12. I have exceeded the annual maximum benefits under my current coverage. Provide documentation from your health insurance carrier identifying the date your annual maximum benefit(s) were met.

Initial one of the statements below:

If the waiver of pre-existing condition is approved, I understand my effective date of coverage will be the day after the cancellation date of my previous health coverage. I agree to pay all MCHA premiums as of this effective date of coverage.

INITIALS: _____

Or

I have reviewed the above list of waiver exceptions and I am not seeking a waiver of the Pre-existing Condition Limitation. I understand that a six (6) month Pre-existing Condition Limitation will be applied to my policy.

INITIALS: _____

J. Applicant's Disclosure Authorization and Declaration: *Required Information*

I represent that the foregoing statements and answers are complete, accurate, and true and that any coverage issued will be in full reliance upon this representation; and I understand and agree that no coverage shall be effective until all requirements have been completed, received and approved by MCHA. I further acknowledge that any inaccurate, false, or fraudulent statements may lead to rescission of coverage issued.

INITIALS: _____

I understand and agree that referring agents are not authorized to interpret, amend, or alter the terms of the MCHA insurance policy, nor are referring agents authorized to bind MCHA in any way.

INITIALS: _____

I understand that MCHA has 30 days to process this enrollment form. Coverage shall be effective the date MCHA receives all materials necessary to constitute a completed enrollment form, including the appropriate premium payment, unless otherwise noted and initialed in section "I. Request for Pre-existing Condition Limitation Waiver" or in section "J. Applicant's Disclosure Authorization and Declaration – "Future Effective Date" (bottom of this page)."

INITIALS: _____

I hereby authorize and request any hospital, clinic, institution, physician, or other person to furnish MCHA or its writing carrier full details of diagnosis, treatment, medical history, and any other information and conclusions about me and any member of my family, and to accept as valid a photocopy of this authorization and my signature. I understand that MCHA keeps this information confidential, but may release it if I authorize release, or under circumstances where state or federal law permits or requires release without authorization, including release to an entity with which MCHA or its writing carrier has contracted for disease management services. For purposes of obtaining information in connection with this application, reinstatement, or change in policy benefits, this release is valid for as long as I remain continuously insured by MCHA. I understand that I am entitled to receive a copy of this release. I understand that I may revoke this authorization by providing written notice to MCHA or its writing carrier. I understand that if I revoke this authorization, this may affect enrollment for me or my dependents.

INITIALS: _____

I authorize any insurance company, institution, employer, or person that has my records or knowledge of my health history or that of any of my family members for whom insurance is requested to give such information to MCHA or its writing carrier. I understand that a reproduction of this authorization shall be as valid as the original. I understand that information obtained will remain subject to the protections of Health Insurance Portability and Accountability Act's privacy standards.

INITIALS: _____

The information I provide on this form and any attachment is private data under Minnesota law. By providing this data, I authorize MCHA and its writing carrier to use and disclose the data to determine my eligibility for the state plan. The law does not require me to provide any data, but my failure to do so will result in my loss of eligibility for the state plan. Any data I provide may also be made available to the employees, agents, directors, or officers of MCHA or its writing carrier. It may also be made available to peer review panels or consultants, contributing members of MCHA, nurse line or disease management entities, hospitals, doctors, and other health care providers involved in my care, health plans and similar entities responsible for payment of my care, the Minnesota Commerce Department, actuarial or research organizations, or other persons authorized by law to receive such data. Unless revoked, this authorization remains in effect as long as I remain continuously insured by MCHA.

INITIALS: _____

I have read the above statements; I agree to supply the data on this form with full knowledge of the information provided in these statements.

X _____ X _____
Signature of Applicant Date Signature of Parent Date
(if applicant is under age 18)

Future Effective Date (Not available if a waiver of the pre-existing limitation is granted)

I choose a future effective date other than the day the completed application and necessary documentation was received.

Yes No

- If "Yes", specify the requested future effective date: _____

K. Premium Payment Options: *Required Information*

Will you have assistance from an organization or employer to pay MCHA premiums? Yes No If "Yes", identify the organization or employer that will assist you:

Department of Human Services (DHS) American Kidney Fund Other _____

Employer/Address/Phone # _____

Choose one premium payment option: (Refer to the Instructions for additional information.)

Monthly premium payment. You are required to use the ACH payment process for monthly billing. See ACH payment process described below.

* TAA (Trade Adjustment Assistance) recipients (see section "H. Eligibility, option "2".) must choose the monthly premium payment option if coordinating premium credits with HCTC (Health Coverage Tax Credit). The ACH payment process will not apply. For the TAA monthly credit, send your monthly MCHA premium invoice to HCTC.

Quarterly premium payment. Choose one of the following options:

Payment by check. A check for the full quarterly premium (3 months) is due on the first day of each calendar quarter (January through March, April through June, July through September, and October through December). Payment should be by personal check, business check, money order or cashier's check.

ACH Payment. See ACH payment process described below.

Note: Whether you choose the monthly or quarterly premium payment option, remember to attach your first premium payment with this application [a month's premium (1 month) or a full quarter's premium (3 months) per your elected payment option above]. You must submit your first premium payment with this application or your application will be considered incomplete and will be returned to you. **The premium payment should be made payable to "MCHA."**

ACH Payment Process:

For the monthly or quarterly ACH process, complete the "ACH Authorization Agreement" below and attach a voided check or savings account deposit slip below. **A checking account deposit slip is NOT acceptable.**

ACH (Automated Clearing House) Authorization Agreement

The Minnesota Comprehensive Health Association (MCHA) through its administrator, Medica, is hereby authorized to deduct my MCHA premium payment due them by electronic debit entries to my checking or savings account indicated below.

Name of Account Holder

Bank Name

Account Type (*check one*):

Checking Savings

Bank Address

City

State

Zip Code

Signature of Account Holder(s):

Account Holder Name (Print)

Account Holder Name (Print)

X _____

X _____

Account Holder Signature

Date

Account Holder Signature

Date

**ATTACH A VOIDED CHECK OR
SAVINGS ACCOUNT DEPOSIT SLIP HERE**

A checking account deposit slip is NOT acceptable

L. Agent Information: *Required information for agent assisted applications*

The Minnesota licensed agent of record receives a one (1)-time \$50 referral fee from MCHA upon acceptance of the application and receipt of the first premium payment.

1. Name (please print):	2. MN Health Insurance License No. and Expiration Date:
3. Issue Payment to (if different then above)	4. Tax ID or Social Security Number:
5. Street Address:	6. Telephone:
7. City, State, Zip Code:	8. E-mail: Fax:
9. Agent's Signature:	10. Date:

Agent Certification of Health Related Rejection: *Required information if applicant is applying under section "H. Eligibility: 1. Health Related Rejection" item "b."*

1. Medical Condition and Approximate Date(s) of Diagnosis	2. Name and Address of Attending Physician or Clinic
3. Name and Address of Insurer or Health Maintenance Organization (HMO) licensed to sell health coverage in Minnesota that will <u>NOT</u> accept the applicant:	
4. I am an insurance producer licensed by the Minnesota Department of Commerce. I certify that the information I have provided is true and correct and I understand that the Minnesota Comprehensive Health Association (MCHA) will rely upon the information I have provided in determining whether or not the applicant is eligible for coverage.	
Agent's Signature:	AGENT INITIALS: _____ Date:

M. Check List: *Required Information*

Incomplete applications will be delayed and the effective date may change if all required information and documentation is not received. All applicable questions must be answered, all required documentation must be included and applicable premium payment must be included for an application to be considered complete.

- I have attached documentation verifying that I have an address and residence in Minnesota for the six (6) month period preceding application to MCHA (*see instructions for section C*).
- I have completed the "Tobacco Designation" section (*see instructions for section D*).
- I have attached the required documentation needed for eligibility (*see instructions for section H*).
- If requesting a waiver of the six (6) month pre-existing condition limitation, I have applied for and have attached the required documentation proving eligibility for a waiver (*see instructions for section I*).
- I have read and signed the "Applicant's Disclosure Authorization and Declaration" section (*see instructions for section J*).
- I have enclosed a check or money order payable to MCHA for a month's premium (1 month) or a full quarter's premium (3 months), (per my elected payment option), and if electing ACH, completed the "ACH Authorization Agreement" and have attached a voided check or savings account deposit slip (*see instructions for section K*).
- I have completed all required applicable sections.
- I have read and initialed all items noted by "Initial: _____."
- If applying under section "I. Request for Pre-Existing Condition Limitation Waiver" reason "2. I have exhausted my continuation coverage under COBRA or other continuation coverage," I have enclosed documentation from my past employer or health insurance carrier stating I have exhausted my continuation rights.

Checklist is completed by: _____ X _____
Print Name Signature Date

Failure to completely answer all questions and to submit required documentation may delay the processing of your application or the date your coverage becomes effective. Your full premium payment must accompany this application.

**Notice to Applicant Regarding
Replacement of Accident and Sickness Insurance**

Minnesota Comprehensive Health Association

**Administered by Medica
Mail Route CW 282
401 Carlson Parkway
Minnetonka, Minnesota 55305-5387**

**SAVE THIS NOTICE!
IT MAY BE IMPORTANT TO YOU IN THE FUTURE!**

According to your application, you intend to terminate existing accident and sickness insurance and replace it with a contract to be issued by the Minnesota Comprehensive Health Association (MCHA). Your new policy provides thirty (30) days within which you may decide without cost whether to keep the policy.

- ♦ You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of the MCHA Medicare Supplement coverage is a wise decision you should terminate your present Medicare supplement policy. You should evaluate the need for other accident and sickness coverage you have that may duplicate the MCHA policy.

STATEMENT TO APPLICANT BY AGENT:

- ♦ I have reviewed your current medical or health insurance coverage. To the best of my knowledge the MCHA Medicare supplement policy will not duplicate your existing Medicare supplement policy because you intend to terminate the existing Medicare supplement policy. The replacement policy is being purchased for the following reason(s) (check one):

- Additional benefits
- Fewer benefits and lower premiums
- No change in benefits, but lower premiums
- Other, specify: _____

- ♦ Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy or certificate.
- ♦ MCHA will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent the time was spent (depleted) under the original policy or certificate.
- ♦ If you still wish to terminate your present policy or certificate and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for MCHA to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed, and before you sign it, review it carefully to be certain that all information has been properly recorded.
- ♦ Do not cancel your present policy or certificate until you have received your new policy and you are sure that you want to keep it.

(Agent's Signature) (Date)

Agent's Name and Address (please type): _____

(Applicant's Signature) (Date)

This notice was delivered to me on:

(Date) (Applicant's Signature)

MCHA

Administered by

MEDICA®

401 Carlson Parkway, Minnetonka, MN 55305-5387

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