Medica Prime Solution® (Cost) Plan

MEDICA®

CHANGE FORM

You should use this form if you want to change from one Medica Prime Solution Medical plan to another. **This form cannot be used to enroll in Medica Prime Solution for the first time or to add or cancel other benefit riders.**

MEMBER INFORMATION (Please type or print)

Legal First Name	M.I.	Last Name		
Home Telephone ( )	E-mail Address (optional – by providing you agree that Medica may send you e-mails)			
Permanent Residence Address	City	State	ZIP	County
Mailing Address (if different from above)	City	State	ZIP	County
Sex ❑ Male ❑ Female	Birth Date	Medica Member Number (required)		

PLAN SELECTION AND EFFECTIVE DATE

❑ Thrift $45 per month
❑ Value $67 per month
❑ Basic $74 per month
❑ Enhanced $142 per month

I am requesting an effective date for the first day of ____________________, 2016.
(month)

NOTE: Plan changes are effective only on the first of the month. The plan change may not be effective prior to Medica's receipt of the change form.

The information provided on this form is accurate and complete. I understand and agree that any omissions or incorrect statements knowingly made by me on this form may invalidate my coverage. I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this form means I have read and understand the contents of this form. **I understand that by changing my plan option, my benefits, premiums and automatic payment will change.** If signed by an authorized representative (as described above), this signature represents that, to the best of that individual's knowledge and belief: 1) this person is authorized under State Law to complete this enrollment and 2) documentation of this authority is available upon request by Medica or by Medicare.

X____ ____________________
Applicant or Authorized Representative Date

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

Name:____________________ Address:____________________

Telephone Number:____________________ Relationship to Member:____________________

Mail completed form to: Medica Medicare Solutions, PO Box 6300, Eau Claire, WI 54702-9713 or fax to: 1-855-250-2166. Or securely upload completed application online at: www.medica.com/EnrollmentUpload

■ Agent use only

____________________ ____________________
Agent Name (please print) ID Number

X____________________ ____________________ _____/_____/_____
Agent Signature Agent Telephone Agent's Receipt Date

© 2015 Medica. Medica is a Cost plan with a Medicare contract. Enrollment in Medica depends on contract renewal.

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WI PRI-CF-16-100-01

WHITE–Medica Enrollment PINK–Member

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