Medica SeniorDental®

2016 ENROLLMENT FORM

MEDICA®
PO Box 6300, Eau Claire, WI 54702-9713
Fax: 1-855-250-2166

MEMBER INFORMATION (Please type or print)			
Legal First Name	M.I.	Last Name	
Permanent Residence Address	City	State	ZIP
Mailing Address *(if different from above)*	City	State	ZIP
E-mail *(optional – by providing you agree that Medica may send you e-mails)*			
Home Telephone ( )	Medicare Claim Number *(required)*		
Which Medica health plan have you applied for or are currently enrolled in? ☐ Medica Prime Solution® Value (Cost) ☐ Medica Prime Solution Basic (Cost) ☐ Medica Prime Solution Enhanced (Cost) ☐ Medica Group Prime Solution℠ (Cost)			
If you are a current Medica member, what is your member ID number?	Desired Effective Date		

Authorization to Obtain or Release Medical Information:

I authorize Medica, its claims administrator, the Centers for Medicare and Medicaid Services (and its designee(s)), plans, brokers of record, providers and any other person or entity to share my health information with each other as is necessary for treatment, payment and health care operations. I also authorize this information to be released to Medicare who may release it for research and other purposes which follow all applicable federal law. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by applicable privacy rules. I further understand that I have the right to revoke this authorization, at any time, by contacting Medica in writing. Medica conditions enrollment on this authorization and my revocation or failure to provide authorization may affect my enrollment. However, if I revoke this authorization, it will not affect any actions already taken by Medica prior to Medica's receipt of the revocation. Unless revoked, this authorization remains in effect until termination of coverage. 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 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 application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that: 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 Medicare.

X _____ _____

Applicant or Authorized Representative Signature Date

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

Name:_____ Address:_____

Telephone Number: Relationship to Member:

Note: Applicant may only enroll once each calendar year.

MN-PRI APPDNT-15-300-01
WI-PRI APPDNT-15-300-01
Y0088_2846a CMS Approved

WHITE – Medica Enrollment PINK – Member

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