

Primary Applicant's Name:

Enrolling in Individual and Family Health Plans

Thank you for being a Medica member!

2020 KANSAS CHANGE FORM

This form may be used to complete the following changes to your current Medica plan:

- Name or address change
Member termination
Newborn or adoption addition
Change in marital status
Qualified dependent addition
Qualified plan change

General Information

- Address or name change (sections B and C) or terming individuals from the policy (Section E) can be completed at any time using this form.
You may only make changes to your current health plan during the annual Open Enrollment Period (Nov. 1 – Dec. 15, 2019) or within 60 days of a special enrollment event.
You may be qualified to lower your monthly premium amount through a Cost Sharing Reduction (CSR) and/or an Advance Premium Tax Credit (APTC).

Coverage Start Date

- If you qualify for a Special Enrollment Period, coverage may start on the first of any month within your Special Enrollment Period. Some special enrollment events, such as having or adopting a child, allow coverage to start on the date of the event.

I'm requesting my coverage starts on (mm/dd/yy):

Form for entering coverage start date (mm/dd/yy)

Have a Question?

Call Customer Service at the number on the back of your Medica ID card.

SECTION

A MEMBER INFORMATION

Note: This section must be completed.

Subscriber

Table with subscriber information: First name, Middle initial, Last name, Social Security number, Current member ID number, Preferred telephone number, Alternative telephone number.

SECTION

B ADDRESS CHANGE\* (if applicable)

Table for address change with columns for Old address and New address, including fields for Street, City, State, Zip code, and Email address (Optional).

Note: Providing your email address does not sign you up for electronic correspondence of plan materials.

SECTION

C NAME CHANGE\* (if applicable)

Table for name change with columns for Old name and New name, including fields for First name, Middle initial, and Last name.

\*A special enrollment event is not needed to report these changes.

**D ENROLLMENT CRITERIA (if applicable)**

Please select your enrollment reason below:

- Annual Open Enrollment Period
- Birth of child
- Adoption or placement for adoption
- Marriage
- Permanent move that changes your Medica plan options
- Involuntary loss of minimum essential coverage due to \_\_\_\_\_  
(e.g. divorce, job loss or COBRA coverage ending)
- Other \_\_\_\_\_


For any special enrollment event, please provide the date of the event: \_\_\_\_\_

 **Note:** Please provide supporting documentation of your special enrollment event with this form.

Would you like to keep your current Medica plan?

Yes     No

If no, please follow the instructions below. We can only process your request if this section is complete.

 **Note:** Network and plan availability varies by place of residence. To view Summary of Benefits and Coverage (SBC) documents, visit [medica.com/IndividualPlansKS](http://medica.com/IndividualPlansKS).

1. Choose your network:

Valid: January 2020 – December 2020

 **Medica Connect<sup>SM</sup>**

Not available in Douglas, Jackson, Jefferson, Johnson, Leavenworth, Miami, Shawnee or Wyandotte county.

 **Medica with Healthier You<sup>SM</sup>**

Available in Sedgwick county only.

 **Select by Medica<sup>SM</sup>**

Available in Douglas, Jackson, Jefferson, Johnson, Leavenworth, Miami, Shawnee and Wyandotte county only.

2. Choose your plan:

**Medica Connect<sup>SM</sup>**

GOLD PLAN	
<input type="checkbox"/>	<b>Gold Copay</b> – 30% coinsurance after deductible
One person coverage:	
<b>Tier 1 – Preferred</b> \$850 deductible	
<b>Tier 2 – Standard</b> \$1,500 deductible	
Family coverage:	
<b>Tier 1 – Preferred</b> \$2,550 deductible	
<b>Tier 2 – Standard</b> \$4,500 deductible	
SILVER PLAN	
<input type="checkbox"/>	<b>Silver Copay</b> – 40% coinsurance after deductible
One person coverage:	
<b>Tier 1 – Preferred</b> \$4,600 deductible	
<b>Tier 2 – Standard</b> \$5,600 deductible	
Family coverage:	
<b>Tier 1 – Preferred</b> \$13,800 deductible	
<b>Tier 2 – Standard</b> \$15,800 deductible	
BRONZE PLANS	
<input type="checkbox"/>	<b>Bronze HSA Plus</b> – 50% coinsurance after deductible
One person coverage:	\$3,200 deductible
Family coverage:	\$9,600 deductible
<input type="checkbox"/>	<b>Bronze HSA</b> – 20% coinsurance after deductible
One person coverage:	\$6,400 deductible
Family coverage:	\$12,800 deductible
<input type="checkbox"/>	<b>Bronze Share Plus</b> – 50% coinsurance after deductible
One person coverage:	\$1,600 deductible
Family coverage:	\$4,800 deductible

**Medica with Healthier You<sup>SM</sup> & Select by Medica<sup>SM</sup>**

GOLD PLANS	
<input type="checkbox"/>	<b>Gold Copay</b> – 30% coinsurance after deductible
One person coverage:	\$850 deductible
Family coverage:	\$2,550 deductible
<input type="checkbox"/>	<b>Gold Share</b> – 35% coinsurance after deductible
One person coverage:	\$550 deductible
Family coverage:	\$1,650 deductible
SILVER PLANS	
<input type="checkbox"/>	<b>Silver Copay</b> – 40% coinsurance after deductible
One person coverage:	\$4,600 deductible
Family coverage:	\$13,800 deductible
<input type="checkbox"/>	<b>Silver Share</b> – 50% coinsurance after deductible
One person coverage:	\$1,000 deductible
Family coverage:	\$3,000 deductible
BRONZE PLANS	
<input type="checkbox"/>	<b>Bronze HSA Plus</b> – 50% coinsurance after deductible
One person coverage:	\$3,200 deductible
Family coverage:	\$9,600 deductible
<input type="checkbox"/>	<b>Bronze HSA</b> – 20% coinsurance after deductible
One person coverage:	\$6,400 deductible
Family coverage:	\$12,800 deductible
<input type="checkbox"/>	<b>Bronze Share Plus</b> – 50% coinsurance after deductible
One person coverage:	\$1,600 deductible
Family coverage:	\$4,800 deductible

**Bronze Copay** – 50% coinsurance after deductible  
 One person coverage:  
**Tier 1 – Preferred** \$7,000 deductible  
**Tier 2 – Standard** \$7,200 deductible  
 Family coverage:  
**Tier 1 – Preferred** \$14,000 deductible  
**Tier 2 – Standard** \$14,400 deductible


**CATASTROPHIC PLAN**

**Catastrophic** – 0% coinsurance after deductible  
 One person coverage: \$8,150 deductible  
 Family coverage: \$16,300 deductible

**Bronze Copay** – 50% coinsurance after deductible  
 One person coverage: \$7,000 deductible  
 Family coverage: \$14,000 deductible

**CATASTROPHIC PLAN**

**Catastrophic** – 0% coinsurance after deductible  
 One person coverage: \$8,150 deductible  
 Family coverage: \$16,300 deductible

 **Note:** Catastrophic plans are only available to individuals and families under 30 or those who qualify for an eligible exemption. Visit [healthcare.gov](http://healthcare.gov) for more information about eligible exemptions and to get the form(s) you need to enroll in coverage.

SECTION

**E ADDITIONS OR TERMINATIONS (if applicable)**

List each person that is being added or termed from the policy. Add additional pages if necessary.

<b>1</b>	First name	Middle initial	Last name	Birthdate (mm/dd/yy)	Tobacco user* <input type="checkbox"/> Yes <input type="checkbox"/> No
	Relationship to applicant			Social Security number	Sex <input type="checkbox"/> M <input type="checkbox"/> F
	Fill in all that apply (optional) <b>Ethnicity if Hispanic/Latino:</b> <input type="checkbox"/> Mexican <input type="checkbox"/> Mexican American <input type="checkbox"/> Chicano/a <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Other: _____ <b>Race:</b> <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Other: _____				
<b>2</b>	First name	Middle initial	Last name	Birthdate (mm/dd/yy)	Tobacco user* <input type="checkbox"/> Yes <input type="checkbox"/> No
	Relationship to applicant			Social Security number	Sex <input type="checkbox"/> M <input type="checkbox"/> F
	Fill in all that apply (optional) <b>Ethnicity if Hispanic/Latino:</b> <input type="checkbox"/> Mexican <input type="checkbox"/> Mexican American <input type="checkbox"/> Chicano/a <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Other: _____ <b>Race:</b> <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Other: _____				
<b>3</b>	First name	Middle initial	Last name	Birthdate (mm/dd/yy)	Tobacco user* <input type="checkbox"/> Yes <input type="checkbox"/> No
	Relationship to applicant			Social Security number	Sex <input type="checkbox"/> M <input type="checkbox"/> F
	Fill in all that apply (optional) <b>Ethnicity if Hispanic/Latino:</b> <input type="checkbox"/> Mexican <input type="checkbox"/> Mexican American <input type="checkbox"/> Chicano/a <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Other: _____ <b>Race:</b> <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Other: _____				

<b>4</b>	First name	Middle initial	Last name	Birthdate (mm/dd/yy)	Tobacco user* <input type="checkbox"/> Yes <input type="checkbox"/> No
	Relationship to applicant			Social Security number	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Fill in all that apply (optional) <b>Ethnicity if Hispanic/Latino:</b> <input type="checkbox"/> Mexican <input type="checkbox"/> Mexican American <input type="checkbox"/> Chicano/a <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Other: _____ <b>Race:</b> <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Other: _____					

**Tobacco user\***

Tobacco user is defined as using tobacco products (for example cigarettes, cigars, smokeless tobacco, e-cigarettes) four or more times a week on average (other than for religious or ceremonial purposes) within the last six months. This only applies to individuals age 18 and over.

SECTION

**F AUTHORIZATION AND REPRESENTATION**

**TO BE SIGNED BY SUBSCRIBER**

I understand and agree this change form will not alter any other limitations, conditions, provisions or exclusions that were part of my policy or application prior to the effective date of this plan change.

**I understand that my premium may be impacted by the change(s) requested on this form. I will be responsible for any additional premium amount due from the effective date of the change(s). I understand that any reduction in premium will be reflected on the monthly billing invoice.**

The information provided on this form is accurate and complete. I understand and agree that any omissions of incorrect statements knowingly made by me on this form may invalidate my coverage.

By signing below, I agree that this change form amends the original application. This change form will be incorporated into and made part of the application form and the policy.

Please provide signature below if subscriber is under age 18:

Signature of subscriber	Date
X	

Signature of parent or legal guardian	Date
X	

I authorize Medica to make the change(s) to my policy as requested by the subscriber and as identified on this change form.

Signature of additional member age 18 or older	Date
X	

Signature of additional member age 18 or older	Date
X	

Signature of additional member age 18 or older	Date
X	

Signature of additional member age 18 or older	Date
X	

**Mail Completed Change Form**  
 Medica Insurance Company  
 Mail Route CW195IFB  
 PO Box 9310  
 Minneapolis, MN 55440-9310

**Fax Completed Change Form**  
 952-992-2511

**FOR OFFICE USE ONLY**

Date received	Effective date of change	Reviewed by	New plan code	Premium change <input type="checkbox"/> Yes <input type="checkbox"/> No
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**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 **1-888-592-8211** (TTY: **711**) or by going to **medica.com**.

# MEDICA®

Mail Route CW195IFB, PO Box 9310, Minneapolis, MN 55440-9310

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### Discrimination is Against the Law

Medica complies with applicable Federal civil rights laws and will not discriminate against any person on the basis of race, color, national origin, age, disability or sex. Medica:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: TTY communication and written information in other formats (large print, audio, other formats).
- Provides free language services to people whose primary language is not English, such as: Qualified interpreters and information written in other languages.

If you need these services, call the number included in this document or on the back of your Medica ID card. If you believe that Medica has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Civil Rights Coordinator, Mail Route CP250, PO Box 9310, Minneapolis, MN 55443-9310, 952-992-3422 (phone/fax), TTY 711, [civilrightscoordinator@medica.com](mailto:civilrightscoordinator@medica.com).

You can file a grievance in person or by mail, fax, or email. You may also contact the Civil Rights Coordinator if you need assistance with filing a complaint.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

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Yog koj xav tau kev pab dawb txhais daim ntawv no, hu rau 1-800-952-3455.

如果您需要我們免費幫您翻譯此文件，請致電 1-800-952-3455。

Nếu quý vị muốn giúp dịch tài liệu này miễn phí, gọi 1-800-952-3455.

Sanadnikun kaffaltiimaleeakkaisiniifhiikamuyoobarbaadd-an 1-800-952-3455 tiinbilbilaa.

إذا كنت ترغب في مساعدة مجانية لترجمة هذا المستند، فاتصل على الرقم 1-800-952-3455.

Если вы хотите получить бесплатную помощь в переводе этого документа, позвоните по телефону 1-800-952-3455.

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Si vous désirez obtenir gratuitement de l'aide pour traduire ce document, appelez le 1 800 952 3455.

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ይህን ሰነድ ለመተርጎም ነጻ እርዳታ ከፈለጉ በ 1-800-952-3455 ይደውሉ።

Ako želite besplatnu pomoć za prijevod ovog dokumenta, nazovite 1-800-952-3455.

T'áá jiik'é díí naaltsoos t'áá nizaadk'ehjí bee shí ká'adoowol ninízingo kojí' hodiílnih, 1-800-952-3455.

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