
Medica Value Choice SolutionSM
APPLICATION FORM

IMPORTANT INFORMATION ABOUT YOUR APPLICATION

1. Please review your application to assure that every question has been answered.
2. Questions in Section E pertain to all applicants. To avoid unnecessary delays, please provide a complete explanation of all “yes” answers. Space is provided under Section 8. Please indicate whether any checkups, physicals, exams, lab work, or x-rays you’ve listed were routine or due to symptoms of illness or injury. Also indicate if the results were normal or if any problems were noted. For each medical condition, illness, or injury, include the onset date and the complete recovery date when appropriate.
3. If approved by the 20th of the month, your application will become effective on the first day of the month following your approval, or if possible, your requested date. See Section C, question 5. Medica will notify you as to whether you have been approved and your effective date. Processing time of your application is approximately 3-4 weeks.
4. Submit your premium payment along with your application.
5. Please complete, sign and date your application and mail to Medica in the enclosed postage-paid envelope. All adults, including dependent children age 18 and over, must sign. Your enrollment form is valid for a period of 60 days from the date you sign it. After 60 days a new application must be completed in full.
6. Please be sure to indicate the deductible plan you are applying for in Section C, question 1.
7. You are 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, you are 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.

ANY MISSING INFORMATION WILL CAUSE DELAYS IN PROCESSING YOUR APPLICATION AND MAY DELAY THE EFFECTIVE DATE OF COVERAGE.

If you have questions or need assistance completing the application, please contact a Medica Sales Service Specialist at 952-992-2080 or 1-800-670-5935 between 8:00 a.m. – 5:00 p.m., Monday through Thursday, and 9:00 a.m. – 5:00 p.m. on Friday.

Thank you for your interest in Medica.

DEFINED TERMS: The term “emergency medical services person” 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*.

The term “bloodborne pathogen” means pathogenic microorganisms that are present in human blood and can cause disease in humans. These pathogens include, but are not limited to, hepatitis B virus (HBV), hepatitis C virus (HCV) and human immunodeficiency virus (HIV).

The term “source individual” means an individual, living or dead, whose blood tissue or potentially infectious body fluids may be a source of bloodborne pathogen exposure to an emergency medical services person. Examples include, but are not limited to, a victim of an accident, injury, or illness, or a deceased person.

The term “significant exposure” means contact likely to transmit a bloodborne pathogen, in a manner supported by the most current guidelines and recommendations of the United States Public Health Service at the time an evaluation takes place, that includes (1) percutaneous injury, contact of mucous membrane or nonintact skin, or prolonged contact of intact skin; and (2) contact, in a manner that may transmit a bloodborne pathogen, with blood, tissue, or potentially infectious body fluids.

E. HEALTH INFORMATION

Check every yes or no box and circle the medical condition(s) for all questions answered yes, for you and your family members applying for coverage. For each question answered "Yes," please complete Section 8.

Section 1: Has any proposed insured in the last 10 years had any diagnosis of, received treatment for or consulted with a physician concerning:

- | | | Yes | No |
|--|--------------------------|--------------------------|--------------------------|
| a. Heart disorders, including but not limited to, chest pain, heart murmur, angina, high blood pressure, congestive heart failure, or cardiovascular disease? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If "Yes," last cholesterol reading? _____ (date _____). Last blood pressure reading? _____ (date _____). | | | |
| b. Circulatory disorders, including but not limited to, peripheral vascular disease, varicose veins, varicose ulcer, phlebitis, anemia, blood clots or other related disorders? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Respiratory disorders, including but not limited to, tuberculosis, asthma, allergies, hay fever, emphysema, chronic bronchitis, lung or respiratory disorder? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Nervous system disorders, including but not limited to, stroke, epilepsy, fainting, dizziness, seizures, headaches, migraines, or any other disease or disorder of the brain or nervous system? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Digestive disorders, including but not limited to, stomach or duodenal ulcer, other ulcer, hernia, colitis, hepatitis,* chronic diarrhea, jaundice, cirrhosis, or any disorder of the liver, gallbladder, stomach, intestine, or rectum? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Renal disorders, including, but not limited to, kidney, bladder, prostate, or urinary disorder? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Musculoskeletal disorders including, but not limited to, arthritis, rheumatism or any disorder of the joints, muscles or bones, any knee, neck, back or spinal trouble, neuritis, sciatica, scoliosis, gout, carpal tunnel syndrome, TMJ or amputation? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Reproductive system disorders including but not limited to any disease or disorder of the breast or reproductive organs (male and female), complication of breast implants, infertility, abnormal menstrual periods, or sexually transmitted disease? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Metabolic disorders, including but not limited to, diabetes or sugar, albumin or blood in the urine? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If "Yes," date of diagnosis _____, last A-1 C reading _____ and date _____, or blood sugar reading _____ and date? _____ | | | |
| j. Eating disorders, unexplained weight loss/gain, fever, enlarged lymph nodes, skin lesions, or any other related disorder? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Cancer, tumor, cysts, or growth of any kind? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Immune system disorders, including but not limited to, HIV* positive, AIDS,* lupus, collagen disease, scleroderma, or any other connective tissue disease? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| m. Blood disorders? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| n. Any disease of the eyes, ears, nose, throat, tonsils, or sinuses? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| o. Mental, emotional, hyperactivity, nervous, anxiety, attention deficit, or personality disorders, including counseling or hospitalization? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| p. Glandular disorders, including but not limited to thyroid, adrenal, pituitary, pancreas, or lymph node/gland enlargement? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| q. Congenital or developmental disorders, including but not limited to, cleft palate, club foot, congenital heart defects, chromosomal abnormalities, physical or cognitive delays or autism? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| r. Skin disorders, acne, psoriasis, warts, or growth? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| s. General fatigue, malaise, mononucleosis, or Epstein-Barr Syndrome? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Section 2: Has any proposed insured ever:

- | | | |
|--|--------------------------|--------------------------|
| a. In the last five years, been evaluated for, treated for, or joined any organization for alcoholism/chemical dependency; consumed alcohol to excess or used drugs improperly without physician approval or been convicted for or had a driver's license suspended for DWI/DUI or moving violation? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Been advised by a medical professional to modify or restrict eating or drinking habits for health purposes? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Been hospitalized (within the past five years)? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Been advised to have surgery or treatment not yet done? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Had any medical treatment, diagnosed or treated health impairment or congenital anomaly not already noted in this enrollment form? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Used tobacco products during the 36 months immediately preceding the date of this application? | <input type="checkbox"/> | <input type="checkbox"/> |
| If "Yes," how much per day? _____ If quit, date? _____ | | |
| g. Had an electrocardiogram, laboratory or diagnostic test or x-ray (other than dental)? | <input type="checkbox"/> | <input type="checkbox"/> |

Section 3:

- | | | |
|---|--------------------------|--------------------------|
| a. Are any proposed insureds currently pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| If "Yes," list due date and if any complications or multiple births are expected. _____ | | |
| b. Is any person not named on the application now pregnant by any proposed insured applying for coverage or is any person applying for coverage anticipating the adoption of a child? | <input type="checkbox"/> | <input type="checkbox"/> |

Section 4:

- | | | |
|---|--------------------------|--------------------------|
| a. Does any proposed insured have any fixation/prosthetic devices present, including but not limited to, plates, screws, pins, implants, shunts, pacemaker, or valve replacement? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. In the last five years, have any of the proposed insured participated in organized racing, including but not limited to, automobile, motorcycle, or power boat racing or any of the following activities: skydiving, ultralight flying, scuba diving, hang gliding, rock or mountain climbing? | <input type="checkbox"/> | <input type="checkbox"/> |

- | | | |
|---|--------------------------|--------------------------|
| Section 5: Is any proposed insured currently disabled, hospitalized or on medical leave? | <input type="checkbox"/> | <input type="checkbox"/> |
|---|--------------------------|--------------------------|

Applicant's Name: _____

E. HEALTH INFORMATION continued

Section 6: Please list the date of last physical exam for all proposed insureds. If female, please also list date of last Pap smear and result.

Person's name	Date of exam	Name & address of physician	Type of exam	Pap smear results

Section 7: Please list all medications taken for any proposed insured in the past 12 months. Add additional page if you need more space.

Person's name	Drug name	Condition	Currently taking?
			<input type="checkbox"/> Yes : Dosage (how many taken each day): <input type="checkbox"/> No : Date (mo/yr) stopped:
			<input type="checkbox"/> Yes : Dosage (how many taken each day): <input type="checkbox"/> No : Date (mo/yr) stopped:
			<input type="checkbox"/> Yes : Dosage (how many taken each day): <input type="checkbox"/> No : Date (mo/yr) stopped:
			<input type="checkbox"/> Yes : Dosage (how many taken each day): <input type="checkbox"/> No : Date (mo/yr) stopped:
			<input type="checkbox"/> Yes : Dosage (how many taken each day): <input type="checkbox"/> No : Date (mo/yr) stopped:

Section 8: If you have answered "Yes" to any questions in Sections E1 through E5, please complete this section. Give complete details. Add an additional page if you need more space.

	Diagnosis, treatment and results	Doctor's name and complete address
Person: _____ Question No.: _____ Date of onset: _____ Days in hospital: _____ Date of complete recovery: _____		
Person: _____ Question No.: _____ Date of onset: _____ Days in hospital: _____ Date of complete recovery: _____		
Person: _____ Question No.: _____ Date of onset: _____ Days in hospital: _____ Date of complete recovery: _____		
Person: _____ Question No.: _____ Date of onset: _____ Days in hospital: _____ Date of complete recovery: _____		

MEDICA®

**Mail Route CP320
PO Box 9310, Minneapolis, MN 55440-9310**

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MEDICA®

PRIVACY NOTICE

Effective June 11, 2003

SUMMARY OF MEDICA'S PRIVACY PRACTICES

There are several state and federal laws requiring Medica to protect our members' personal information. The most recent regulations (45 CFR parts 160 and 164) are tied to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These regulations require health plans such as Medica to provide you with information about how your personal information may be used and disclosed. The regulations describe how Medica must protect this information and how you can access your personal information. Medica must adhere to the terms of its privacy notice. Medica may change or amend its privacy notice; however, if it's materially changed, Medica will issue you a revised privacy notice within sixty (60) days from the date it is amended.

The law permits Medica to use and disclose your personal information for purposes of treatment, payment, and health care operations without first obtaining your authorization. There are other limited circumstances in which Medica may use and disclose your personal information without your authorization such as public health, regulatory, and law enforcement activities. Whether personal information is used or disclosed with or without authorization, Medica uses or discloses personal information only to those persons who need to know and only the minimum amount necessary to perform the required activity.

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.

These duties, responsibilities, and rights are described in more detail in Medica's Privacy Notice.

Please Note: Medica's Privacy Notice does not apply to members whose employers are self-insured. If your employer is self-insured, you need to contact your employer for more information about your health plan's privacy practices.

MEDICA'S PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THIS NOTICE IS INTENDED FOR MEDICA INSURANCE COMPANY, MEDICA HEALTH PLANS, AND MEDICA HEALTH PLANS OF WISCONSIN MEMBERS (COLLECTIVELY REFERRED TO AS "MEDICA"). IF YOU ARE A COVERED PERSON IN A SELF-INSURED GROUP HEALTH PLAN, YOU HAVE A RIGHT TO RECEIVE A PRIVACY NOTICE DIRECTLY FROM YOUR GROUP HEALTH PLAN.

Medica is committed to protecting and maintaining the privacy and confidentiality of your personal information. This notice describes our privacy practices and our related legal duties. It also describes your rights relating to personal information about you.

What is personal information?

As a health plan, Medica obtains, maintains, uses and discloses information about our members such as name, address, telephone number, Social Security number, age, date of birth, gender, marital status, dependent information, and health history. In addition, Medica obtains and generates information about our members' enrollment, physical and mental health conditions, prior approval for services, referrals, coverage determinations, claims data, medical records, and payment for health care services. This and any other information that individually identifies you is called "personal information."

How does Medica protect your personal information?

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 uses and discloses only the minimum amount of personal information necessary to perform the required activity. In addition to physical and technological safeguards, Medica has adopted administrative policies and procedures that

require its employees, business associates and health care providers to treat personal information as private. Medica provides training in privacy procedures to its employees. We protect the personal information of applicants and former members just as we protect the personal information of current Medica members.

Under what circumstances does Medica use or disclose personal information?

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. Other examples of routine activities include:

- Enrollment and eligibility, benefits management, and utilization management
- Customer service
- Coordination of care
- Health improvement and disease management (for example, sending information on treatment alternatives or other health-related benefits)
- Premium billing and claims administration
- Complaints and appeals
- Underwriting, actuarial studies, and premium rating
- Regulatory and accreditation oversight, and legal compliance
- Credentialing and quality assessment
- Business planning or management and general administrative activities (for example, employee training and supervision, legal consultation, accounting, auditing)
- Anti-fraud activities

With whom does Medica share personal information?

Medica shares personal information for routine activities with health care providers, accrediting organizations, regulatory agencies, law enforcement, group policyholders, and our business associates, who are under contract to provide services to or on behalf of Medica (for example, claims processing services).

There are also other activities for which Medica uses or discloses your personal information without authorization, as permitted by law. These activities include:

- public health activities (such as disease intervention);
- health care oversight activities required by law or regulation (such as professional licensing, member satisfaction surveys, quality surveys, or insurance regulation);
- law enforcement purposes (such as fraud prevention); and
- assisting in the avoidance of a serious and imminent threat to health or safety.

Medica has policies that limit the disclosure of personal information to employers. However, Medica must share some personal information (for example, enrollment information) with a group policyholder or its designee to administer its business. The group policyholder or designee is responsible to safeguard the personal information from being used for purposes other than administering health plan benefits.

Medica may occasionally contact you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Under what circumstances can you authorize Medica to use and disclose your personal information?

From time to time, Medica is interested in using or disclosing personal information for purposes other than treatment, payment, health care operations, or as required by law. In these situations, Medica is required to obtain your written authorization. Medica will not be able to release the particular personal information

until we have obtained your authorization. You have the right to decide not to authorize Medica to use or disclose your personal health information in these situations. You will not encounter any adverse consequences if you elect not to authorize a particular activity. You, or your authorized representative (such as a power of attorney or court-appointed guardian), may revoke an authorization that has been given in the past, except to the extent that Medica has already relied and acted on your permission.

What are your rights to your personal information?

You have the following rights with regard to the personal information that Medica has about you. You, or your personal representative on your behalf, may:

Request restrictions of disclosure. You have the right to ask Medica to limit how it uses and discloses personal information about you. Your request must be in writing and be specific as to the restriction requested and to whom it applies. Even though you ask, Medica is not required to agree to such restrictions. If we do honor your request, Medica agrees not to use or disclose your personal information as you requested except in emergency situations in which you require treatment. To exercise this right, please contact Customer Service at the telephone number on the back of your identification card, or contact us at PO Box 9310, Minneapolis, MN 55440-9310.

Request receipt of confidential communications. You have the right to ask us to communicate with you about confidential matters by alternative means or at alternative locations. Medica will accommodate reasonable requests, but the requests must be in writing and you must clearly state that the disclosure of all or part of the personal information could endanger you. An example of alternative communications would include a request to contact you at a certain telephone number or to use an address that is different than the one in our files. To exercise this right, please contact Customer Service at the telephone number on the back of your identification card, or contact us at PO Box 9310, Minneapolis, MN 55440-9310.

Inspect or obtain a copy of your personal information. In order to administer its health plans, Medica stores members' personal information in a designated record set. You have the right to inspect and obtain a copy of the personal information you are entitled to under the law. For example, certain personal information, such as psychotherapy notes, cannot be inspected or copied. Your request must be in writing and on Medica's authorization form. Your request will be honored, to the extent possible, within thirty (30) days of receipt. Medica may impose a reasonable charge for providing copies of personal information. To exercise this right, please contact Customer Service at the telephone number on the back of your identification card, or contact us at PO Box 9310, Minneapolis, MN 55440-9310.

Request an amendment or deletion. You have the right to submit a written request to amend personal information about you in Medica's designated record set that you believe is wrong or incomplete. Medica will act on your request within thirty (30) days of receipt. Medica is not obligated to honor your request. If Medica disagrees, you may file a written statement of disagreement. Medica may prepare a rebuttal. If it does, Medica will provide you with a copy of the rebuttal. Your request, statement of disagreement and rebuttal will be maintained in Medica's designated record set. To exercise this right, please contact Customer Service at the telephone number on the back of your identification card, or contact us at PO Box 9310, Minneapolis, MN 55440-9310.

Request an accounting of disclosures. You have the right to receive an accounting or listing of disclosures Medica has made of your personal information subject to certain exceptions. Your request for an accounting cannot go back more than six years from the date the request was made (but not before April 14, 2003). To exercise this right, please contact Customer Service at the telephone number on the back of your identification card, or contact us at PO Box 9310, Minneapolis, MN 55440-9310.

Request a copy of this notice. You may ask for and obtain a separate paper copy of this notice. To exercise this right or for questions about this notice, please contact Customer Service at the telephone number on the back of your identification card, or contact us at PO Box 9310, Minneapolis, MN 55440-9310.

Right to complain about Medica's privacy practices. If you feel your privacy rights have been violated, you may file a complaint. You will not be retaliated against for filing a complaint. To file a complaint with Medica, please contact Customer Service at the telephone numbers and address listed above. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. To do so, write to the Office for Civil Rights, U.S. Department of Health & Human Services, 233 N. Michigan Ave. Suite 240, Chicago, IL 60601.

About this notice.

Medica is required by law to maintain the privacy of personal information and to provide this notice. We reserve the right to change the terms of our notice and to make the new notice effective for all personal information that we maintain. If we make such a change, we will send you a revised notice by mail or electronically. By law, Medica must abide by the terms of the privacy notice currently in effect. This notice is effective June 11, 2003.

As used in this notice, "Medica" refers to the family of health plan businesses that includes Medica Health Plans, Medica Health Plans of Wisconsin and Medica Insurance Company. This notice is provided to subscribers enrolled in fully-insured Medica products, for the benefit of themselves and their dependents.

SUMMARY OF THE MINNESOTA INSURANCE FAIR INFORMATION REPORTING ACT

Access to Personal Information

In reviewing your application for health insurance coverage, Medica may use the personal information it has collected and may request additional information from you or your family members. Personal information is individually identifiable information, including your name, address and health record information. It does not include privileged information such as information relating to a claim for insurance benefits or a civil or criminal proceeding. Personal information may be obtained electronically, in writing, or by telephone or personal interviews.

You have the following rights with regard to the personal information:

1. You have the right to know the nature and substance and source of the personal information Medica has obtained about you.
2. You have the right to access personal information or you may request a copy of the information, or a reasonably described portion of the information, whichever you prefer.
3. If health information has been supplied by a health care institution or a health professional to Medica, Medica must identify for you the identity of the health professional or health care institution that supplied the information.
4. If you request, Medica must identify all persons or organizations with which we have shared the information in the past two years.

In addition, you may request Medica either to supply health record information directly to you or to a designated health professional licensed to provide health care with respect to the condition to which the information relates. However, if the health professional or health care institution that provided the information to Medica indicates in writing that the release of the health record information is detrimental to your physical or mental health, or is likely to cause you to inflict self-harm or to harm another, Medica may provide the information directly to you only with the approval of the health professional with treatment responsibility for the condition to which the information relates.

Medica has the right to charge you a copying fee information provided to you. If you are requesting this information due to an adverse underwriting decision, then this information is available to you at no charge.

Correction, Amendment, or Deletion of Personal Information

If you disagree with any of the information in our file about either you or your family members, you have the right to ask Medica to correct, amend or delete the information. If we refuse to make your requested change, you may appeal to the Commissioner of Commerce.

You may submit a concise written statement giving the reason why you disagree with us and provide what you believe to be the correct information. Medica must make this statement a permanent part of our records and disclose it, along with all other personal information on you or your family members in a manner described below.

Disclosing Information

Medica may not disclose any information concerning you and your family members without prior authorization, except in certain situations. Personal information is not frequently disclosed and is only released to accomplish specific needs for the data. These examples include:

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- 1). **State Regulatory Authority:** We may provide information to the Minnesota Department of Commerce and Health with respect to their regulatory authority. Information may be released to governmental licensing or regulatory boards for the purpose of reviewing health care providers conduct or service. Information may be released to other governmental or law enforcement authorities to assist in preventing and prosecuting fraud and other illegal activities.
- 2). **Health Care Providers:** We may disclose information to a physician, clinic, hospital, other health care provider or peer review organization needing the information in order to conduct a business, professional or insurance function of Medica.
- 3). **Research:** General disclosures may be made for actuarial or research studies. However, this information would not include you or your family member's names. Upon completion of a study, the information is either destroyed or returned to Medica.

For Questions

If you have any questions regarding any of the information in this summary, please direct them to:

Medica
Attn: Individual Admin.
P.O. Box 9310, Mail Route 80237
Minneapolis, MN 55440-9310

Please provide Medica with your name, social security number and if applicable, you're Medica ID number and employer name if you choose to request any of the information mentioned in this summary.

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