Primary Applicant's Name: _____

2025 Missouri Application Form

Enrolling in Individual and Family plans

Medica

Information about this policy

- This application is for an individual/family policy only. The policy cannot be offered as a group health plan.
- We use your Social Security number(s) to identify you and your family and to report your coverage status to the federal government. The IRS requires Medica to report this information.
- You can apply at **Medica.com/ShopPlans-WellFirst**. This may reduce your application's processing time.
- You may be eligible for financial assistance to pay your monthly premium or reduce the out-of-pocket costs of your health care expenses. To see if you are eligible, visit **Healthcare.gov**.
- This policy does not include pediatric dental services. Pediatric dental is an essential health benefit that can be purchased as a stand-alone plan through the Health Insurance Marketplace. For more information visit **Healthcare.gov**.

Completing your application

- Complete all sections within the application thoroughly and accurately. Missing or inaccurate information will delay your application.

Submitting your application

- We can only accept your application during the annual Open Enrollment Period (Nov. 1 – Jan. 15) or within 60 days of a special enrollment event. Some life events allow you to apply 60 days prior to the event. See the plan's Policy of Coverage for more information.
- We cannot process your application until we receive your full first month's premium payment.
- Please complete, sign, and date your application and fax or mail it to Medica. All adults, including dependents age 18 and over, must sign. If the primary applicant is under age 18, a guarantor, parent, or legal guardian also must sign.
- See Section D for information on when your coverage starts. Please allow five to seven business days to process your application. **Do not cancel any existing coverage until we issue your policy, you accept it, and your first payment has been processed.**
- This application will become a part of your contract. Please make a copy for your personal records.

Have a question?

Please call a Medica Sales Consultant at **1 (855) 347-5001** (TTY: **711**) between 8 a.m. and 5 p.m. CT, Monday through Thursday, and 9 a.m. and 5 p.m. CT on Friday.

A ENROLLMENT CRITERIA

Please select your enrollment reason below:

❍ Annual Open Enrollment Period

❍ Recently established QSEHRA or ICHRA*

Employer name:_____

❍ Special Enrollment Period (Select the special enrollment event below):

- ❍ Birth of child
- ❍ Adoption or placement for adoption
- ❍ Marriage, divorce or legal separation
- ❍ Involuntary loss of minimum essential coverage due to _____ (e.g. divorce, job loss or COBRA coverage ending)
- ❍ Other _____
- ❍ Permanent move that changes your Medica plan options
- ❍ Recently established QSEHRA or ICHRA*

  Employer name:_____

For any new or special enrollment event, please provide the date of the event (MM/DD/YY): ____ / ____ / ____

⚠ **Note:** If you chose Special Enrollment Period, please complete this application within 60 days of the event chosen above and provide supporting documentation of your special enrollment event with this application.

Adding a dependent from birth or adoption is not limited to the 60-day enrollment period. You may add a new dependent from birth or adoption to your existing policy at any time. However, you must pay the premium for the policy back to the date of the child's birth or adoption.

*Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) and Individual Coverage Health Reimbursement Arrangement (ICHRA)

Primary Applicant's Name: _____

B APPLICANT INFORMATION

Primary applicant *(If you are applying on behalf of a minor, indicate their name here)*

First name	Middle initial	Last name

Parent/guardian *(Only if applying on behalf of a minor)*

First name	Middle initial	Last name

Applicant's home address

Street

City	State	Zip Code	County

Applicant's billing address *(If different than home address) This is where your monthly invoice will go.*

❍ Please send all correspondence to my billing address

Street

City	State	Zip Code

Correspondence address *(If different than home or billing address) This is where all other mailings will go.*

Street

City	State	Zip Code

Marital status	**Preferred telephone number**	
❍ Single ❍ Married ❍ Domestic partnership		Best time to call ❍ Morning ❍ Afternoon ❍ Evening

Email address *(Optional – We'll use your email to provide you information to help you get the most of your coverage.)*

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

Primary Applicant's Name: _____

B APPLICANT INFORMATION CONTINUED

List each person applying for coverage. Add additional pages if necessary.

1

First name | Middle initial | Last name | Birthdate (mm/dd/yy) | Tobacco user*
❍ Yes ❍ No

Relationship to applicant | Social Security number | Sex
❍ Male ❍ Female

Fill in all that apply (optional)

Ethnicity if Hispanic/Latino:
❍ Mexican ❍ Mexican American ❍ Chicano/a ❍ Puerto Rican ❍ Cuban ❍ Other: _____

Race:
❍ White ❍ Black or African American ❍ American Indian or Alaska Native ❍ Filipino ❍ Japanese ❍ Korean ❍ Asian Indian ❍ Chinese
❍ Vietnamese ❍ Other Asian ❍ Native Hawaiian ❍ Guamanian or Chamorro ❍ Samoan ❍ Other Pacific Islander ❍ Other: _____

2

First name | Middle initial | Last name | Birthdate (mm/dd/yy) | Tobacco user*
❍ Yes ❍ No

Relationship to applicant | Social Security number | Sex
❍ Male ❍ Female

Fill in all that apply (optional)

Ethnicity if Hispanic/Latino:
❍ Mexican ❍ Mexican American ❍ Chicano/a ❍ Puerto Rican ❍ Cuban ❍ Other: _____

Race:
❍ White ❍ Black or African American ❍ American Indian or Alaska Native ❍ Filipino ❍ Japanese ❍ Korean ❍ Asian Indian ❍ Chinese
❍ Vietnamese ❍ Other Asian ❍ Native Hawaiian ❍ Guamanian or Chamorro ❍ Samoan ❍ Other Pacific Islander ❍ Other: _____

3

First name | Middle initial | Last name | Birthdate (mm/dd/yy) | Tobacco user*
❍ Yes ❍ No

Relationship to applicant | Social Security number | Sex
❍ Male ❍ Female

Fill in all that apply (optional)

Ethnicity if Hispanic/Latino:
❍ Mexican ❍ Mexican American ❍ Chicano/a ❍ Puerto Rican ❍ Cuban ❍ Other: _____

Race:
❍ White ❍ Black or African American ❍ American Indian or Alaska Native ❍ Filipino ❍ Japanese ❍ Korean ❍ Asian Indian ❍ Chinese
❍ Vietnamese ❍ Other Asian ❍ Native Hawaiian ❍ Guamanian or Chamorro ❍ Samoan ❍ Other Pacific Islander ❍ Other: _____

4

First name | Middle initial | Last name | Birthdate (mm/dd/yy) | Tobacco user*
❍ Yes ❍ No

Relationship to applicant | Social Security number | Sex
❍ Male ❍ Female

Fill in all that apply (optional)

Ethnicity if Hispanic/Latino:
❍ Mexican ❍ Mexican American ❍ Chicano/a ❍ Puerto Rican ❍ Cuban ❍ Other: _____

Race:
❍ White ❍ Black or African American ❍ American Indian or Alaska Native ❍ Filipino ❍ Japanese ❍ Korean ❍ Asian Indian ❍ Chinese
❍ Vietnamese ❍ Other Asian ❍ Native Hawaiian ❍ Guamanian or Chamorro ❍ Samoan ❍ Other Pacific Islander ❍ Other: _____

Primary Applicant's Name: _____

B APPLICANT INFORMATION CONTINUED

List each person applying for coverage. Add additional pages if necessary.

5

First name	Middle initial	Last name	Birthdate (mm/dd/yy)	Tobacco user*
				❍ Yes ❍ No

Relationship to applicant	Social Security number	Sex
		❍ Male ❍ Female

Fill in all that apply (optional)

Ethnicity if Hispanic/Latino:

❍ Mexican ❍ Mexican American ❍ Chicano/a ❍ Puerto Rican ❍ Cuban ❍ Other: _____

Race:

❍ White ❍ Black or African American ❍ American Indian or Alaska Native ❍ Filipino ❍ Japanese ❍ Korean ❍ Asian Indian ❍ Chinese
❍ Vietnamese ❍ Other Asian ❍ Native Hawaiian ❍ Guamanian or Chamorro ❍ Samoan ❍ Other Pacific Islander ❍ Other: _____

6

First name	Middle initial	Last name	Birthdate (mm/dd/yy)	Tobacco user*
				❍ Yes ❍ No

Relationship to applicant	Social Security number	Sex
		❍ Male ❍ Female

Fill in all that apply (optional)

Ethnicity if Hispanic/Latino:

❍ Mexican ❍ Mexican American ❍ Chicano/a ❍ Puerto Rican ❍ Cuban ❍ Other: _____

Race:

❍ White ❍ Black or African American ❍ American Indian or Alaska Native ❍ Filipino ❍ Japanese ❍ Korean ❍ Asian Indian ❍ Chinese
❍ Vietnamese ❍ Other Asian ❍ Native Hawaiian ❍ Guamanian or Chamorro ❍ Samoan ❍ Other Pacific Islander ❍ Other: _____

7

First name	Middle initial	Last name	Birthdate (mm/dd/yy)	Tobacco user*
				❍ Yes ❍ No

Relationship to applicant	Social Security number	Sex
		❍ Male ❍ Female

Fill in all that apply (optional)

Ethnicity if Hispanic/Latino:

❍ Mexican ❍ Mexican American ❍ Chicano/a ❍ Puerto Rican ❍ Cuban ❍ Other: _____

Race:

❍ White ❍ Black or African American ❍ American Indian or Alaska Native ❍ Filipino ❍ Japanese ❍ Korean ❍ Asian Indian ❍ Chinese
❍ Vietnamese ❍ Other Asian ❍ Native Hawaiian ❍ Guamanian or Chamorro ❍ Samoan ❍ Other Pacific Islander ❍ 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 21 and over.

Primary Applicant's Name: _____

C PRODUCT SELECTION

Valid: January 2025 - December 2025

⚠ Network and plan availability varies by place of residence. To see what is available in your area please go to **Medica.com/ShopPlans-WellFirst** for more information.

Note: To view Summary of Benefits and Coverage (SBC) documents, visit **Medica.com/ShopPlans-WellFirst**.

Key for table:

❍ Plan name

WellFirst℠
GOLD PLAN
❍ Gold Standard ❍ Gold $0 Copay PCP Visits ❍ Gold Copay Plus
SILVER PLANS
❍ Silver Standard ❍ Silver $0 Copay PCP Visits ❍ Silver Copay Plus
BRONZE PLANS
❍ Expanded Bronze Standard ❍ Bronze $0 Copay PCP Visits ❍ Bronze Share
CATASTROPHIC PLAN
❍ Catastrophic

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

Primary Applicant's Name: _____

D COVERAGE START DATE

Open Enrollment Period (Nov. 1 – Jan. 15)

Unless otherwise stated by the Marketplace or Medica, during open enrollment your coverage under this Policy:

- For plan selections made between November 1 and December 15, will be effective January 1; and
- For plan selections made between December 16 and January 15, will be effective February 1.

Special Enrollment Period

If you qualify for a Special Enrollment Period, coverage may start on the first day 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. In most cases, you must enroll within 60 days of your life event. If you do not choose a coverage start date it will be the next available date.

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

E PAYMENT INFORMATION

You can find your quoted premium amount at **Medica.com/ShopPlans-WellFirst**. You can also contact Medica or your broker for the quoted premium amount. Premium amounts are effective Jan. 1 – Dec. 31, 2025.

⚠ **Note:** Your first month's payment should be the quoted premium amount. Coverage will not start until your first month's payment is received. You must submit payment within 30 days of completing your application to start coverage.

First month and ongoing payments:

Please select how you'd like to pay your first month and/or ongoing premium payments with the Premium Payment Options form attached.

Primary Applicant's Name: _____

F OTHER INSURANCE INFORMATION

Is any person named on the application *eligible* for Medicare Parts A, B, C or D?..... ❍ Yes ❍ No

Does any person named on the application have other health insurance coverage?..... ❍ Yes ❍ No

If yes, please provide their current health coverage information by completing the insurance information below:

Coverage start date	Coverage end date	List all persons covered under policy	Name of insurance company	Type of insurance
				❍ COBRA ❍ Individual ❍ Group ❍ Medicare ❍ Part A ❍ Part B ❍ Part C ❍ Part D
				❍ COBRA ❍ Individual ❍ Group ❍ Medicare ❍ Part A ❍ Part B ❍ Part C ❍ Part D
				❍ COBRA ❍ Individual ❍ Group ❍ Medicare ❍ Part A ❍ Part B ❍ Part C ❍ Part D

If current coverage is with Medica, please provide the member ID number: _____

If current coverage is through an employer, please indicate the employer's name:

_____

⚠ **Note:** If you are replacing your existing Medica coverage with this new coverage you must notify us if you'd like to cancel your current coverage. **We recommend you do not cancel any existing coverage until we issue your policy and you accept it.**

Primary Applicant's Name: _____

G AUTHORIZATION AND REPRESENTATION

TO BE SIGNED BY APPLICANTS

I represent that the information provided herein is true and complete to the best of my knowledge and belief. I understand that Medica may rescind coverage back to the start date of coverage for fraud and intentional material misrepresentation.

I understand that:

1. This information will be used for enrollment and eligibility for benefits.
2. Medica may re-disclose the information without authorization as permitted by law, which means it may no longer be protected by privacy rules.
3. I may revoke this authorization in writing. Revocation will not affect any actions taken by Medica prior to Medica's receipt of the revocation. Unless revoked, this authorization will remain in effect for the term of my coverage.
4. Benefits under the policy will be based upon the selection made in Section C.
5. This plan does not include coverage for pediatric dental services and coverage for these services can be purchased through a separate pediatric dental plan.
6. I have the right to see and correct my personal information in accordance with the law.
7. I have the right to review Medica's Privacy Notice before signing this application and to request a copy at any time.
8. I authorize Medica to release information related to my Medica enrollment to my insurance agent should I choose to name one. This includes information related to any applicant listed within this application. This authorization will terminate one year from the date the application is signed.
9. I authorize Medica to disclose any information in its possession to any of my providers who will manage or coordinate my care.
10. I authorize my insurance agent should I choose to name one to enter and transmit this application form online to Medica electronically.

⚠ **FURTHER AUTHORIZATION:**

I authorize Medica (by checking below) to contact me by mail, email and/or telephone with information on related products or services that Medica offers or sponsors, or other topics of interest. This may include third-party health or non-health related information. I understand that in some circumstances Medica is paid if I buy a third party's product or services.

❍ I authorize Medica to use and disclose my contact information in the way described above.

Please keep a copy of your completed application for your records. If you are approved for coverage, this copy will become a part of your contract.

Please provide signature below if primary applicant is under age 18:

⚠

Signature of primary applicant	Date	Signature of parent or legal guardian	Date
X		X	

As an additional applicant named on this application, I authorize Medica to disclose my protected health information to the primary applicant regarding this application.

Signature of additional applicant age 18 or older	Date	Signature of additional applicant age 18 or older	Date
X		X	
Signature of additional applicant age 18 or older	Date	Signature of additional applicant age 18 or older	Date
X		X	

Primary Applicant's Name: _____

G AUTHORIZATION AND REPRESENTATION CONTINUED

Note: Finished filling out your application? Be sure you have all the following pieces:

1. Original application, including signatures of everyone over the age of 18 who is listed on the application
2. Estimated initial payment for first month's premium (Submit with the Premium Payment Options form or check/money order)

Additional items you may attach to your application:

3. Supporting documentation if you're enrolling through a special enrollment period

Mail Completed Application
Medica Central Health Insurance Company
Mail Route CW195IFB
PO Box 9310
Minneapolis, MN 55440-9310

Fax Completed Application
(952) 992-2511

H AGENT USE ONLY

I certify that I have reviewed this application. If application was completed by agent, agent certifies that he/she personally completed this application, that each question was asked separately, that the answers recorded in this application are complete and accurate as given.

Signature of agent X	Date	Agent number
Print agent's name	Telephone number	

I FOR OFFICE USE ONLY

Date received	Policy start date	Payment ID	Amount	Promo code

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 (855) 347-5001** (TTY: **711**) or by going to **Medica.com**.

Medica®

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

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.

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.

If you want free help translating this document, call 1-800-952-3455.

Si desea recibir asistencia gratuita para la traducción de este documento, llame al 1-800-952-3455.

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 الرقم1-800-952-3455.

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

ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອຟຣີໃນການແປເອກະສານນີ້, ໃຫ້ໂທຫາ 1-800-952-3455.

이 문서를 번역하는 데 무료로 도움을 받고 싶으시면 1-800-952-3455로 전화하십시오.

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

နမ္နာလိဉ်ဘဉ်တာ်မၤစၢၤကလီလၢတာ်ကွဲးကျိာ်ထံလာ်အံၤဧၣယိ, ကိး 1-800-952-3455.

Kung nais mo ng libreng tulong sa pagsasalin ng dokumentong ito, tumawag sa 1-800-952-3455.

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'adoowoł ninízingo kojį' hodíílnih, 1-800-952-3455.

Wenn Sie kostenlose Hilfe zur Übersetzung dieses Dokuments wünschen, rufen Sie 1-800-952-3455 an.

COMIFB-0119-K