Primary Applicant's Name: _____

2024 Kansas Change Form

Individual + family plans

Medica

You can use this form to complete the following changes to your current plan:

- Name or address change
- Add new dependents
- Remove covered dependent(s)
- Change in marital status
- Qualified plan change

General information

- Address or name change (Sections B and C) or removing individuals from the policy (Section F) 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, 2023 – Jan. 15, 2024) or within 60 days of a special enrollment event. For a list of special enrollment events and to make your new plan selection, see Section D.
- You may be qualified to lower your monthly premium amount through a subsidy (advanced premium tax credit). To see if you qualify, please visit **HealthCare.gov.**

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. In most cases, you must enroll within 60 days of your life event. If you don't choose a coverage start date, then it will be the next available date.

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

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

Fax Completed Change Form
(952) 992-2511

Questions?
Call Member Services at the number on the back of your Medica ID card.

Primary Applicant's Name: _____

A MEMBER INFORMATION

⚠ **Note:** You need to complete this section.

Subscriber

First name	Middle initial	Last name	Social Security number

Current member ID number	Preferred telephone number	Alternative telephone number

B ADDRESS CHANGE* (if applicable)

Old address	**New address**
Street	Street
City	City
State Zip code	State Zip code
Email address (Optional)	Email address (Optional)

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

C NAME CHANGE* (if applicable)

Old name			**New name**		
First name	Middle initial	Last name	First name	Middle initial	Last name

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
- ❍ Recently established QSEHRA or ICHRA^
- ❍ Involuntary loss of minimum essential coverage due to _____ (e.g., divorce, job loss or COBRA coverage ending)
- ❍ Other _____

For any new or special enrollment event, please provide the date of the event (mm/dd/yy): ____ / ____ / ____

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

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

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

Primary Applicant's Name: _____

E PRODUCT SELECTION

Valid: Jan. 1 – Dec. 31, 2024

⚠ **Note**: Network availability varies by place of residence. To view Summary of Benefits and Coverage (SBC) documents, visit **Medica.com/ShopPlans-KS**.

Key for table
❍ Plan name
Coinsurance after deductible/individual deductible/family deductible

Would you like to keep your current plan?	
❍Yes ❍No	If no, please follow the instructions below. We can only process your request if this section is complete.

Select by Medica℠
Available for residents in the following counties: Johnson, Leavenworth, Miami or Wyandotte
GOLD PLANS
❍ **Gold Copay $0 PCP**
30%/$1,750/$3,500
❍ **Gold Standard**
25%/$1,500/$3,000
SILVER PLAN
❍ **Silver Standard**
40%/$5,900/$11,800
BRONZE PLANS
❍ **Bronze Copay $0 PCP**
50%/$7,850/$15,700
❍ **Bronze Share Plus**
50%/$2,750/$5,500
❍ **Expanded Bronze Standard**
50%/$7,500/$15,000
❍ **Bronze Standard**
5%/$9,100/$18,200
❍ **Bronze Premier**
50%/$1,800/$3,600

Medica Connect℠
Only available for residents in the following counties: Barber, Butler, Chase, Chautauqua, Clark, Comanche, Cowley, Edwards, Elk, Finney, Ford, Grant, Gray, Greenwood, Hamilton, Harper, Harvey, Haskell, Hodgeman, Kearny, Kingman, Kiowa, Marion, McPherson, Meade, Montgomery, Morton, Pawnee, Pratt, Reno, Rice, Sedgwick, Seward, Stafford, Stanton, Stevens, Sumner or Wilson
GOLD PLAN
❍ **Gold Standard**
25%/$1,500/$3,000
SILVER PLAN
❍ **Silver Standard**
40%/$5,900/$11,800
BRONZE PLANS
❍ **Bronze Share Plus**
50%/$2,750/$5,500
❍ **Bronze Basic**
5%/$9,000/$18,000
❍ **Expanded Bronze Standard**
50%/$7,500/$15,000
CATASTROPHIC PLAN
❍ **Catastrophic**
0%/$9,450/$18,900
Only available for residents in the following counties: Butler, Chase, Chautauqua, Cowley, Elk, Greenwood, Harper, Harvey, Kingman, Marion, McPherson, Montgomery, Reno, Rice, Sedgwick, Sumner or Wilson

⚠ **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: _____

F COVERED DEPENDENTS (if applicable)

List each person that is being added or removed from the policy. 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 ❍M ❍F

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: _____

Status ❍Add ❍Terminate

2

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

Relationship to applicant	Social Security number	Sex ❍M ❍F

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: _____

Status ❍Add ❍Terminate

3

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

Relationship to applicant	Social Security number	Sex ❍M ❍F

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: _____

Status ❍Add ❍Terminate

4

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

Relationship to applicant	Social Security number	Sex ❍M ❍F

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: _____

Status ❍Add ❍Terminate

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: _____

G 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	

H FOR OFFICE USE ONLY

Date received	Effective date of change	Reviewed by	New plan code	Premium change ❍Yes ❍No

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.**

Primary Applicant's Name: ______________________________

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.

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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 nínízingo kojį' hodíílnih, 1-800-952-3455.

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

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