

MEDICA®

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MINNESOTA

**Medica Solo<sup>SM</sup>**

**Medica Encore<sup>SM</sup>**

*Change Form.....*



**CHANGE FORM**

**E. AUTHORIZATION (read this section, then sign and date the form)**

I understand and agree that 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 I will not be allowed to return to a lower deductible amount without providing a health history and application.

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 charges. I understand that any reduction in premium will be reflected on the billing invoice.

The information provided on this form is accurate and complete. I understand and agree that any omissions or 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 and will be incorporated into and made part of the application form and the policy.

Member's Signature: **X** \_\_\_\_\_ Date: \_\_\_\_\_

I authorize Medica to make the changes to this policy as requested by the Member and identified on this Change Form.

Guarantor's Signature: **X** \_\_\_\_\_ Date: \_\_\_\_\_  
(Please complete if member is under age 18)

*A person who submits a change form or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.*

**OFFICE USE ONLY**

Eff. Date of Change	Reviewed By	Date	New Plan Code	PE Mo.	Premium Change <input type="checkbox"/> Y <input type="checkbox"/> N	Rollover <input type="checkbox"/> Y <input type="checkbox"/> N
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*Send completed form to:*

**Medica**

Mail Route CP320

PO Box 9310

Minneapolis, MN 55440-9310

**MEDICA®**

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**PO Box 9310, Minneapolis, MN 55440-9310**

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