Individual & Family Plans Enrollment Application

When to apply

- Applications will be accepted during the annual Open Enrollment Period (November 1, 2024 – January 15, 2025).
- You may be eligible to enroll in a UCare Individual & Family Plan outside the Open Enrollment Period if you experience a qualifying life event. The timeframe for electing coverage varies with the type of event, but is generally no later than 60 calendar days after the date on which the event occurs. Refer to section IV. Additional information is available at **ucare.org.**
- If you have a Medicare plan or are eligible for a Medicare plan, please see our Medicare plan options on **ucare.org.**

How to apply

- Complete all sections of the application thoroughly and accurately, including signatures for all adults and dependents age 18 and older. Applications with missing or inaccurate information will be returned for completion, which may delay the effective date of your coverage.
- You can apply online at **ucare.org.** Applying online may reduce processing time.

How to submit an application

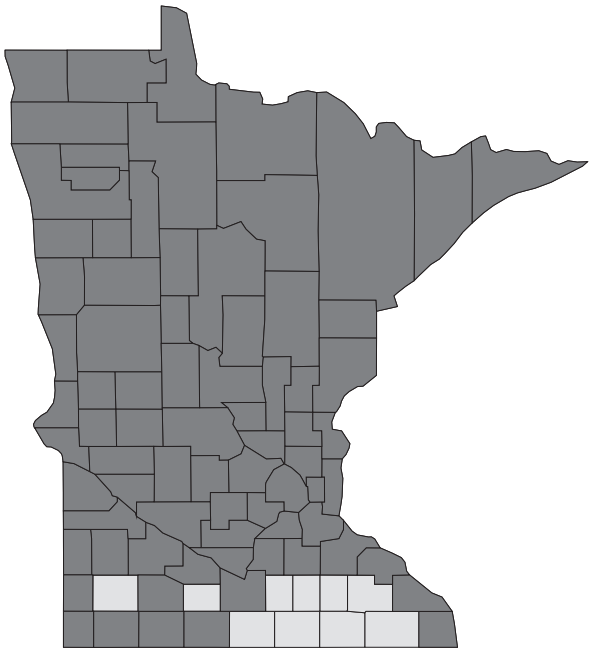
- Your application cannot be processed without the initial month's premium payment.
- Mail the completed application including additional documentation or written proof required to UCare, PO Box 52, Minneapolis, MN, 55440-9682 or fax it to 612-617-3898.
- This application will become a part of your contract. Make a copy of the completed application for your records.

Effective date of coverage

- Applying during Open Enrollment (November 1, 2024 – January 15, 2025): Coverage effective date is January 1, 2025. Your application must be received by December 15, 2024 in order to begin coverage on January 1, 2025.
- Applying during a Special Enrollment Period due to a qualifying life event: The coverage effective date depends on the type of qualifying life event. Refer to section IV.
- Do not cancel any existing coverage until we issue your policy and you accept it.

Eligibility

To be eligible for coverage, you must be a Minnesota resident in the county of Aitkin, Anoka, Becker, Beltrami, Benton, Big Stone, Blue Earth, Brown, Carlton, Carver, Cass, Chippewa, Chisago, Clay, Clearwater, Cook, Cottonwood, Crow Wing, Dakota, Douglas, Goodhue, Grant, Hennepin, Houston, Hubbard, Isanti, Itasca, Jackson, Kanabec, Kandiyohi, Kittson, Koochiching, Lac qui Parle, Lake, Lake of The Woods, Le Sueur, Lincoln, Lyon, Mahnomen, Marshall, Martin, McLeod, Meeker, Mille Lacs, Morrison, Nicollet, Nobles, Norman, Otter Tail, Pennington, Pine, Pipestone, Polk, Pope, Ramsey, Red Lake, Redwood, Renville, Rice, Rock, Roseau, Scott, Sherburne, Sibley, Stearns, Stevens, St. Louis, Swift, Todd, Traverse, Wabasha, Wadena, Washington, Wilkin, Winona, Wright or Yellow Medicine.



Contact us

- Please contact UCare Individual & Family Plan simplifiers at 1-855-307-6975 (TTY: 1-800-688-2534) 8 am to 5 pm, Monday through Friday if you have questions or need assistance completing your application.
- Work with an independent broker in your area to select a health plan and enroll. Find a broker who works with UCare at **ucare.org/ifp-brokers.**

Individual & Family Plans Enrollment Application

Please use black ink

BROKER INFORMATION

Broker NPN

Broker name

I. APPLICANT INFORMATION

☐ I am a new applicant ☐ I am currently a UCare member, adding a dependent. Current Member ID: _____

☐ I am currently a UCare member and I want to enroll in a different plan. Current Member ID: _____

PRIMARY APPLICANT			
First name	Middle name	Last name	Suffix

Legal sex	Date of birth	Coverage date	Social Security number[1]
☐ Male ☐ Female ☐ Choose not to disclose			

Primary address line one

Primary address line two

☐ Mailing address is different than primary residence

Mailing address line one

Mailing address line two

Phone number	Phone type
	☐ Cell ☐ Home ☐ Work

Email address	What is your marital status?	Tobacco user[2]
	☐ Single ☐ Married	☐ Yes ☐ No

Are you of Hispanic, Latino, or Spanish origin? *(optional)* ☐ Yes ☐ No

Race/ethnicity *(optional)*

☐ American Indian or Alaskan Native	☐ Asian	☐ Indian	☐ Black/African American
☐ Chinese	☐ Filipino	☐ Guamanian/Chamorro	☐ Japanese
☐ Korean	☐ Native Hawaiian	☐ Samoan	☐ Vietnamese
☐ White	☐ An Asian race not listed above	☐ A Pacific Islander race not listed above	☐ Another race not listed

[1]Social Security numbers (SSNs) help us process applications more efficiently and are requested for IRS tax reporting requirements but are not required.

[2]Tobacco user is defined as using tobacco products 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.

II. COMPLETE THIS SECTION FOR EACH PERSON, OTHER THAN THE PRIMARY SUBSCRIBER

DEPENDENT ONE

First name, middle initial, last name, suffix		Birth date (mm/dd/yyyy)	Tobacco user[1] ☐ Yes ☐ No
Relationship to applicant	Social Security number[2]	Does dependent one have a disability? ☐ Yes ☐ No	Legal sex ☐ Male ☐ Female ☐ Choose not to disclose

Are you of Hispanic, Latino, or Spanish origin? *(optional)* ☐ Yes ☐ No

Race/ethnicity *(optional)*

☐ American Indian or Alaskan Native	☐ Asian	☐ Indian	☐ Black/African American
☐ Chinese	☐ Filipino	☐ Guamanian/Chamorro	☐ Japanese
☐ Korean	☐ Native Hawaiian	☐ Samoan	☐ Vietnamese
☐ White	☐ An Asian race not listed above	☐ A Pacific Islander race not listed above	☐ Another race not listed

If an individual's last name is different from the applicant's, explain the reason:

DEPENDENT TWO

First name, middle initial, last name, suffix		Birth date (mm/dd/yyyy)	Tobacco user[1] ☐ Yes ☐ No
Relationship to applicant	Social Security number[2]	Does dependent two have a disability? ☐ Yes ☐ No	Legal sex ☐ Male ☐ Female ☐ Choose not to disclose

Are you of Hispanic, Latino, or Spanish origin? *(optional)* ☐ Yes ☐ No

Race/ethnicity *(optional)*

☐ American Indian or Alaskan Native	☐ Asian	☐ Indian	☐ Black/African American
☐ Chinese	☐ Filipino	☐ Guamanian/Chamorro	☐ Japanese
☐ Korean	☐ Native Hawaiian	☐ Samoan	☐ Vietnamese
☐ White	☐ An Asian race not listed above	☐ A Pacific Islander race not listed above	☐ Another race not listed

If an individual's last name is different from the applicant's, explain the reason:

[1]Tobacco user is defined as using tobacco products 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.

[2]Social Security numbers (SSNs) help us process applications more efficiently and are requested for IRS tax reporting requirements but are not required.

DEPENDENT THREE

First name, middle initial, last name, suffix		Birth date (mm/dd/yyyy)	Tobacco user[1] ☐ Yes ☐ No
Relationship to applicant	Social Security number[2]	Does dependent three have a disability? ☐ Yes ☐ No	Legal sex ☐ Male ☐ Female ☐ Choose not to disclose

Are you of Hispanic, Latino, or Spanish origin? *(optional)* ☐ Yes ☐ No

Race/ethnicity *(optional)*

☐ American Indian or Alaskan Native	☐ Asian	☐ Indian	☐ Black/African American
☐ Chinese	☐ Filipino	☐ Guamanian/Chamorro	☐ Japanese
☐ Korean	☐ Native Hawaiian	☐ Samoan	☐ Vietnamese
☐ White	☐ An Asian race not listed above	☐ A Pacific Islander race not listed above	☐ Another race not listed

If an individual's last name is different from the applicant's, explain the reason:

DEPENDENT FOUR

First name, middle initial, last name, suffix		Birth date (mm/dd/yyyy)	Tobacco user[1] ☐ Yes ☐ No
Relationship to applicant	Social Security number[2]	Does dependent four have a disability? ☐ Yes ☐ No	Legal sex ☐ Male ☐ Female ☐ Choose not to disclose

Are you of Hispanic, Latino, or Spanish origin? *(optional)* ☐ Yes ☐ No

Race/ethnicity *(optional)*

☐ American Indian or Alaskan Native	☐ Asian	☐ Indian	☐ Black/African American
☐ Chinese	☐ Filipino	☐ Guamanian/Chamorro	☐ Japanese
☐ Korean	☐ Native Hawaiian	☐ Samoan	☐ Vietnamese
☐ White	☐ An Asian race not listed above	☐ A Pacific Islander race not listed above	☐ Another race not listed

If an individual's last name is different from the applicant's, explain the reason:

[1]Tobacco user is defined as using tobacco products 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.

[2]Social Security numbers (SSNs) help us process applications more efficiently and are requested for IRS tax reporting requirements but are not required.

DEPENDENT FIVE			
First name, middle initial, last name, suffix		Birth date (mm/dd/yyyy)	Tobacco user[1] ☐ Yes ☐ No
Relationship to applicant	Social Security number[2]	Does dependent five have a disability? ☐ Yes ☐ No	Legal sex ☐ Male ☐ Female ☐ Choose not to disclose

Are you of Hispanic, Latino, or Spanish origin? *(optional)* ☐ Yes ☐ No

Race/ethnicity *(optional)*

☐ American Indian or Alaskan Native	☐ Asian	☐ Indian	☐ Black/African American
☐ Chinese	☐ Filipino	☐ Guamanian/Chamorro	☐ Japanese
☐ Korean	☐ Native Hawaiian	☐ Samoan	☐ Vietnamese
☐ White	☐ An Asian race not listed above	☐ A Pacific Islander race not listed above	☐ Another race not listed

If an individual's last name is different from the applicant's, explain the reason:

[1]Tobacco user is defined as using tobacco products 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.

[2]Social Security numbers (SSNs) help us process applications more efficiently and are requested for IRS tax reporting requirements but are not required.

If you are the Power of Attorney (POA)/authorized representative, and are signing on behalf of this enrollee, provide the following information:

Name _____ Relationship to enrollee _____

Address _____ Phone number _____

Please include a copy of the POA agreement or other legal document with application to: UCare Enrollment, P.O. Box 52, Minneapolis, MN 55440. We must have the POA agreement on file in order to respond to future requests made by the POA.

III. EFFECTIVE DATE

Open Enrollment Period (November 1, 2024 – January 15, 2025)
Your effective date of coverage is January 1, 2025. Your application and initial premium must be received by the 15th of December in order to begin coverage on January 1, 2025 as set forth herein. We cannot back date coverage.

Special Enrollment Period
Your effective date of coverage depends on the type of qualifying life event. See section IV for details on available effective dates.

I am requesting my coverage start on (mm/dd/yyyy): ☐

IV. SPECIAL ENROLLMENT PERIOD EVENT INFORMATION

Below is a list of Special Enrollment Period qualifying life events. If you qualify for any of these events, you can apply for coverage outside of the annual Open Enrollment Period (November 1, 2024 – January 15, 2025). You must submit your completed application documents during your qualifying event's Special Enrollment Period to get health coverage. If you're applying during a Special Enrollment Period, please check the appropriate box below that describes your qualifying event. Make sure to submit the signed attestation with your completed application and first month's premium.

Please provide the date of event (mm/dd/yyyy): ☐

SPECIAL ENROLLMENT PERIOD EVENT (you must select one)

☐ **1. Job loss**
You or someone in your household lost coverage through employment in the last 60 days. Your coverage will start on the first day of the next month.

☐ **2. Policy/plan year ending (for a plan or policy you bought yourself)**
The plan year for the coverage you or someone in your household is enrolled in ended in the last 60 days. Your coverage will start on the first day of the next month.

☐ **3. Adoption/legal change**
Gained or lost a dependent through adoption, foster care, child support or other court order in the last 60 days. Your coverage will start on the first day of the next month.

☐ **4. COBRA expired**
COBRA expired for you or someone in your household in the last 60 days. Your coverage will start on the first day of the next month.

☐ **5. Divorce or legal separation**
You or someone in your household divorced or legally separated and lost coverage in the last 60 days. Your coverage will start on the first day of the next month.

☐ **6. Death**
You or someone in your household lost coverage due to a death in the last 60 days. Your coverage will start on the first day of the next month.

☐ **7. Aging off parent or guardian's plan**
You stopped qualifying as a dependent on a parent or guardian's plan in the last 60 days. Your coverage will start on the first day of the next month.

☐ **8. Loss of Medicaid or CHIP**
You or someone in your household lost Medicaid or CHIP coverage in the last 60 days. Your coverage will start on the first day of the next month.

☐ **9. Moved to a new residence**
You changed your permanent residence in the last 60 days. Your coverage will start on the first day of the next month.

☐ **10. New baby**
You or someone in your household had a baby in the last 60 days. Your coverage will start on the first day of the next month.

☐ **11. Marriage**
You or someone in your household got married in the last 60 days. Your coverage will start on the first day of the next month.

☐ **12. New HRA offer from an employer**
You or someone in your household was offered individual coverage health reimbursement arrangement (ICHRA) or qualified small employer health reimbursement arrangement (QSEHRA) from an employer in the last 60 days or expects to in the next 60 days. Your coverage will start on or after your HRA benefit begins.

☐ **13. U.S. citizenship (legal residency)**
You became a U.S. citizen or legal resident in the last 60 days. Your coverage will start on the first day of the next month.

☐ **14. Income decrease**
In the last 60 days, your household income decreased (generally income decreased to $19,000 or less for one person and $40,000 or less for a family of four) and your eligibility changes for tax credits or cost-sharing reductions. Must be enrolled through MNsure in a qualified health plan.

SPECIAL ENROLLMENT PERIOD EVENT
☐ **15. American Indian or Alaskan Native** Enrolled members of a federally recognized tribe can enroll in a new plan or change from one plan to another one time per month, year-round.
☐ **16. Released from incarceration** You were released from serving a term in prison or jail in the last 60 days. Your coverage will start on the first day of the next month.

I, _____, hereby attest that the above chosen qualifying event has occurred and accurately reflects the situation. If requested, will provide the proper documentation. I do hereby attest that this information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission or concealment of material fact may subject me to administrative, civil or criminal liability.

Signature: _____ Date: _____

You need to submit your completed application documents during your qualifying event's Special Enrollment Period to get health coverage. If you don't, you'll need to wait to enroll in a health plan until 1.) the next annual Open Enrollment Period (November 1, 2024 – January 15, 2025) or 2.) you qualify for another Special Enrollment Period.

V. COVERAGE SELECTION

1. You must be a resident in one of the following counties in Minnesota in order to apply for coverage:

Aitkin, Anoka, Becker, Beltrami, Benton, Big Stone, Blue Earth, Brown, Carlton, Carver, Cass, Chippewa, Chisago, Clay, Clearwater, Cook, Cottonwood, Crow Wing, Dakota, Douglas, Goodhue, Grant, Hennepin, Houston, Hubbard, Isanti, Itasca, Jackson, Kanabec, Kandiyohi, Kittson, Koochiching, Lac qui Parle, Lake, Lake of The Woods, Le Sueur, Lincoln, Lyon, Mahnomen, Marshall, Martin, McLeod, Meeker, Mille Lacs, Morrison, Nicollet, Nobles, Norman, Otter Tail, Pennington, Pine, Pipestone, Polk, Pope, Ramsey, Red Lake, Redwood, Renville, Rice, Rock, Roseau, Scott, Sherburne, Sibley, Stearns, St. Louis, Stevens, Swift, Todd, Traverse, Wabasha, Wadena, Washington, Wilkin, Winona, Wright or Yellow Medicine.

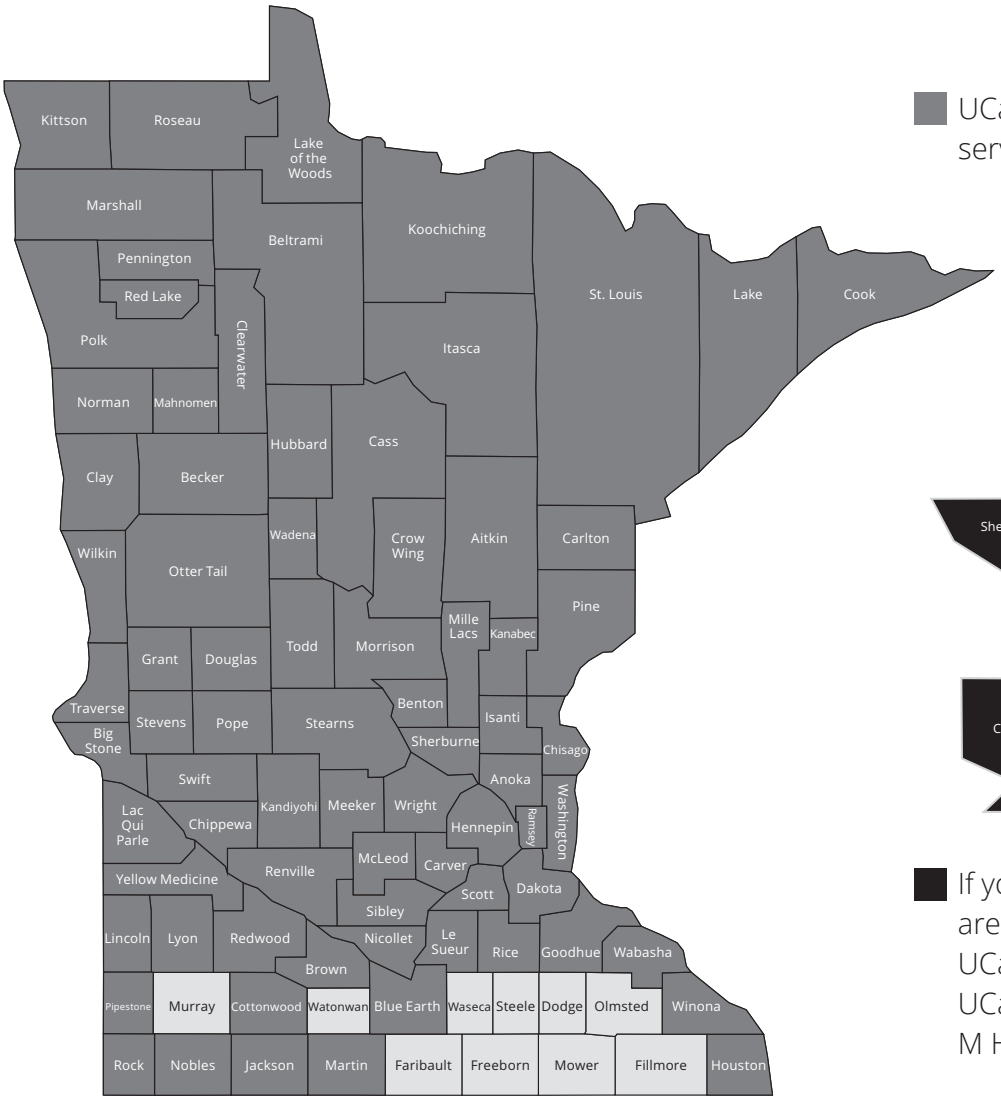
By completing this enrollment application I attest that I am a resident of a Minnesota county listed above at the time of completing this form.

2. Review plan options on pages 9-11.

3. Current member with a Special Enrollment Period event (check one):

a. ☐ I want to keep my current plan option but am adding a dependent

b. ☐ I want to enroll in a different plan option — select option on page 11



UCare Individual & Family Plans service area

If you live in the 10-county metro area, you have a choice between UCare Individual & Family Plans or UCare Individual & Family Plans with M Health Fairview.

Copay plans

UCare Individual & Family Plans and UCare Individual & Family Plans with M Health Fairview			
	Core*	**Bronze Access****	**Bronze**
Individual deductible	$9,450	$8,000	$5,500
Family deductible *For a family of two or more*	$18,900	$16,000	$11,000
Individual out-of-pocket limit	$9,450	$9,450	$9,100
Family out-of-pocket limit *For a family of two or more*	$18,900	$18,900	$18,200
Office visit / urgent care	$30 copay first three primary care office visits, then 0% after deductible	$60 copay first three primary, specialist and urgent care visits, then 45% after deductible	$60 copay first three visits, then 35% after deductible
Telehealth visits	Covered as a primary care visit	Covered as a primary are visit	Covered as a primary care visit
Retail and online visits	No charge	No charge	No charge
Preventive care	No charge	No charge	No charge
Preferred generic drugs	0% coinsurance after deductible	$15 copay per prescription $30 copay for 90-day supply	$15 copay per prescription $30 copay for 90-day supply
Non-preferred generic drugs	0% coinsurance after deductible	$25 copay per prescription $50 copay for 90-day supply	$25 copay per prescription $50 copay for 90-day supply
Preferred brand drugs	0% coinsurance after deductible	$200 copay per prescription	$200 copay per prescription
Emergency room	0% coinsurance after deductible	45% coinsurance after deductible	35% coinsurance after deductible
Diagnostic tests	0% coinsurance after deductible	45% coinsurance after deductible	35% coinsurance after deductible
Hospital stays	0% coinsurance after deductible	45% coinsurance after deductible	35% coinsurance after deductible

*Available to those who are under age 30 or those with a federal hardship exemption based on coverage being unaffordable.
**Available only with the UCare Individual & Family Plan broad network.

Copay plans

UCare Individual & Family Plans and UCare Individual & Family Plans with M Health Fairview			
	Silver and Silver StandardRx**	**Gold Access****	**Gold and Gold StandardRx****
Individual deductible	$2,500	$1,700	$950
Family deductible *For a family of two or more*	$5,000	$3,400	$1,900
Individual out-of-pocket limit	$8,400	$8,000	$7,400
Family out-of-pocket limit *For a family of two or more*	$16,800	$16,000	$14,800
Office visit / urgent care	$40 per primary care visit (unlimited), $95 copay per specialist visit (unlimited, including Urgent Care)	$20 copay per primary care visit (unlimited), $35 copay per specialist visit (unlimited), 20% coinsurance after deductible per Urgent Care visit	$20 copay per primary care visit (unlimited), $35 copay per specialist visit (unlimited, including Urgent Care)
Telehealth visits	No charge	Covered as a primary care visit	Covered as a primary care visit
Retail and online visits	No charge	No charge	No charge
Preventive care	No charge	No charge	No charge
Preferred generic drugs	$10 copay per prescription $20 copay for 90-day supply	$15 copay per prescription $30 copay for 90-day supply	$5 copay per prescription $10 copay for 90-day supply
Non-preferred generic drugs	$20 copay per prescription $40 copay for 90-day supply	$20 copay per prescription $40 copay for 90-day supply	$15 copay per prescription $30 copay for 90-day supply
Preferred brand drugs	$175 copay per prescription	20% coinsurance after deductible	$125 copay per prescription
Emergency room	30% coinsurance after deductible	20% coinsurance after deductible	$500 first visit, then 20% coinsurance after deductible
Diagnostic tests	30% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Hospital stays	30% coinsurance after deductible	20% coinsurance afterdeductible	20% coinsurance after deductible

*Available to those who are under age 30 or those with a federal hardship exemption based on coverage being unaffordable.
**Available only with the UCare Individual & Family Plan broad network.

HSA-compatible plans

UCare Individual & Family Plans and UCare Individual & Family Plans with M Health Fairview		
	Bronze HSA	**Silver HSA**
Individual deductible	$8,050	$3,200
Family deductible *For a family of two or more*	$16,100	$6,400
Individual out-of-pocket limit	$8,050	$6,800
Family out-of-pocket limit *For a family of two or more*	$16,100	$13,600
Preventive care	No charge	No charge
After the deductible		
Office visit / urgent care	0% coinsurance	25% coinsurance
Retail and online visits	0% coinsurance	25% coinsurance
Preferred generic drugs	0% coinsurance	25% coinsurance
Non-preferred generic drugs	0% coinsurance	25% coinsurance
Preferred brand drugs	0% coinsurance	25% coinsurance
Emergency room	0% coinsurance	25% coinsurance
Diagnostic tests	0% coinsurance	25% coinsurance
Hospital stays	0% coinsurance	25% coinsurance

4. Make your plan selection.

Copay plans

UCare Individual & Family Plan

- ☐ Core*
- ☐ Bronze Access**
- ☐ Bronze
- ☐ Silver StandardRx
- ☐ Gold Access**
- ☐ Gold StandardRx

UCare Individual & Family Plan with M Health Fairview

- ☐ Core*
- ☐ Bronze
- ☐ Silver
- ☐ Gold

HSA-compatible plans

UCare Individual & Family Plan

- ☐ Bronze HSA
- ☐ Silver HSA

UCare Individual & Family Plan with M Health Fairview

- ☐ Bronze HSA
- ☐ Silver HSA

*Available to those who are under age 30 or those with a federal hardship exemption based on coverage being unaffordable.
**Available only with the UCare Individual & Family Plan broad network.

VI. INITIAL PAYMENT AND ONGOING PAYMENT ELECTIONS (You must complete both steps)

STEP 1. INITIAL MONTH'S PREMIUM PAYMENT (you must select and complete one)

I am a new applicant and elect to make my initial premium payment as follows:

☐ I enclosed a check (personal or cashier's) with my application

☐ I authorize initial payment via Electronic Funds Transfer (EFT)*

Account type: ☐ Checking ☐ Savings

Name on bank account _____

Bank ADA/routing number _____

Bank account number _____

Bank name _____

Print name of applicant _____

Signature of bank account holder _____ Date _____

Signature of bank account holder (if joint account) _____

STEP 2. ONGOING PAYMENT (you must select and complete one)

☐ Pay via EFT (electronic funds transfer) through your online member account at **ucare.org**

☐ Pay via debit or credit card through your online member account at **ucare.org**

☐ Pay by phone by calling us at 1-877-903-0070 or TTY 1-800-688-2534

*Electronic Funds Transfer (EFT) premium collection option, which utilizes the Automated Clearing House (ACH) system to effectively and accurately debit your designated account each payment cycle. The ACH funds transfer system is used nation-wide by member financial institutions. In the event your account lacks sufficient funds, you may be charged a processing fee of up to $25 fee for each occurrence. If you have questions, please contact UCare at 1-877-903-0070 (TTY 1-800-688-2534).

VII. AUTHORIZATIONS for UCare and others to receive, disclose and use ("share") your health information

I, the applicant for myself and any minor dependents, or, if applicable, I the spouse or dependent age 18 or older, authorize UCare, my health plan, my insurer, and my providers to share my Health Information specifically by and with, but not limited to, the following:

- UCare, for its plan administration, payment and/or operations
- My broker — about the status of my application
- Payers — Medicare, Medicaid and/or any other government health care programs, any other insurance company, health maintenance organization, payer network organization including an accountable care-type organization or network or other payer, and the contractors and subcontractors of such entities, for the payment and operations purposes of UCare and each of them
- UCare's contractor and subcontractor service providers to assist UCare in carrying out its plan administration, payment and operations functions — including but not limited to coordinating benefits between payers, coordinating out-of-pocket payments for medical and pharmacy claims, pharmacy benefit management, disease and care management, utilization review and management, and other customer service and health claim-related activities

I understand and agree as follows:

- I will execute and submit all authorizations required by any third party (e.g., providers) for the release of my Health Information to UCare for plan administration, payment and/or operations purposes
- My "Health Information" includes, but is not limited to, my "protected health information" or "PHI" as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and my "health records" as defined by Minnesota Statutes section 144.293; and includes my past, present and future health records, which include but are not limited to, medical and pharmacy claims and related case notes, and information derived from them. These specifically include, if UCare has them, claims and case notes about HIV/AIDS, mental health and psychotherapy, substance use, and/or chemical dependency treatment.
- I am not allowed to modify the authorizations in this application; and if I do so, the application will not be valid
- This authorization shall remain valid as long as I am enrolled in health care coverage provided or administered by UCare and its affiliates, unless I revoke it as described below. A copy of this authorization is valid as the original.
- This authorization is effective notwithstanding any other authorizations or revocations of authorizations that I enter into or have already entered into with UCare, its affiliates and/or any providers. This authorization and any expiration or revocation thereof does not affect or change the routine sharing of my Health Information by or between UCare, its affiliates and/or any providers that is permitted or required under HIPAA or applicable state law.
- Information released pursuant to this authorization may be re-disclosed as permitted by law, in which case I understand that it may no longer be protected under federal privacy rules. I may revoke this authorization prospectively at any time, but only by submitting a valid written revocation to UCare's Customer Service Department; and can obtain revocation information from the Customer Service Department by calling 1-877-903-0070 (TTY 1-800-688-2534). Such revocation will be effective only after UCare receives it, and it will not affect UCare's or others' actions taken prior to receipt of the revocation.

VIII. ACKNOWLEDGEMENTS

To the best of my knowledge and belief the answers to the questions and the statements made on this completed application are true and complete, and I agree that any telephone conversations required to clarify information on this completed application are part of this application.

I further understand and agree as follows:

- If this form is submitted because of a special enrollment event, then this form amends my original application and will be incorporated into and made a part of the application and contract.
- Payment of a claim does not prevent UCare from denying future claims or taking any lawful action it determines appropriate, including rescission of the contract and seeking repayment of claims already paid.
- If UCare approves this application, it will issue an individual contract for me and, if applicable, the dependents listed in this application.
- UCare does not issue individual coverage through an arrangement with an employer.
- In the event of a conflict between this application and the contract, the contract governs and UCare will administer coverage in accordance with the contract.
- UCare is not responsible for any action taken by an employer that results in this coverage being considered group coverage under state or federal law; and such employer is solely responsible for any such finding.
- I am not allowed to modify the acknowledgements in this application; and if I do so, the application will not be valid. UCare reserves and has the right to, in its sole discretion, request and/or rely on other documentation, to determine if any person listed in this application satisfies the requirements of this application.
- UCare will act in reliance upon the information I have provided herein.
- I must update the information that I have provided on this application and resubmit it if any changes to the information take place between submission of the application and the effective date of coverage; and, failing to notify UCare of any change, providing false information or the omission of relevant information on this application which materially affects either the acceptance of risk or hazard assumed by UCare may result in denial of claims, rescission of coverage, or an increase in premiums, and may be considered insurance fraud.

IX. SIGNATURES

By signing below, I certify under penalty of perjury that: (i) I have completely read and fully understand the terms and conditions of this application; (ii) all the representations in this application are made by me, or by the applicant on my behalf, and are true and complete; and (iii) I agree to the statements, authorizations, acknowledgements and terms of this application. I understand that any misrepresentation may result in the forfeiture of insurance coverage and that I will be personally responsible for all claims affected by such misrepresentation. I understand that I may be subject to penalties under law if I provide false or untrue information.

Applicant signature	Date	Print full name

Notice of Nondiscrimination

UCare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. UCare does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

We provide aids and services at no charge to people with disabilities to communicate effectively with us, such as TTY line, or written information in other formats, such as large print.

If you need these services, contact us at **612-676-3200 (voice)** or toll free at **1-800-203-7225 (voice)**, **612-676-6810 (TTY)**, or **1-800-688-2534 (TTY)**.

We provide language services at no charge to people whose primary language is not English, such as qualified interpreters or information written in other languages.

If you need these services, contact us at the **number on the back of your membership card** or **612-676-3200** or toll free at **1-800-203-7225 (voice)**; **612-676-6810** or toll free at **1-800-688-2534 (TTY)**.

If you believe that UCare 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 an oral or written grievance.

Oral grievance

If you are a current UCare member, please call the number on the back of your membership card. Otherwise please call **612-676-3200** or toll free at **1-800-203-7225 (voice)**; **612-676-6810** or toll free at **1-800-688-2534 (TTY)**. You can also use these numbers if you need assistance filing a grievance.

Written grievance
Mailing Address
UCare
Attn: Appeals and Grievances
PO Box 52
Minneapolis, MN 55440-0052
Email: cag@ucare.org
Fax: 612-884-2021

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
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 612-676-3200/1-800-203-7225（TTY：612-676-6810/1-800-688-2534）。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 612-676-3200/1-800-203-7225 (телетайп: 612-676-6810/1-800-688-2534).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 612-676-3200/1-800-203-7225 (መስማት ለተሳናቸው: 612-676-6810/1-800-688-2534).

ဟ်သူဉ်ဟ်သး–နမ့်ကတိၤ ကညီ ကျိာ်ဏယိ, နမၤနှ် ကျိာ်ဏတၢ်မၤစၢၤလ၊ တလာ်ဘူဉ်လာ်စ့ၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ.
ကိး 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយា ភាសារ័ខ្មរ, រសរាជំនួយរ័ផ្នកភាសា ដោយមិនគិតឈ្លួល គឺអាចមានសំរាប់បំរ័អ្នក។ ចូរ ទូរស័ព្ទ 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534)។

ملحوظة :إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان .اتصل برقم 612-676-3200/1-800-203-7225 (رقم هاتف الصم والبكم: 612-676-6810/1-800-688-2534).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 612-676-3200/1-800-203-7225 (ATS : 612-676-6810/1-800-688-2534).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).