Individual & Family Plans Enrollment Application

When to apply

- Applications will be accepted during the annual Open Enrollment Period (November 1, 2025 – January 15, 2026).
- 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.**

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

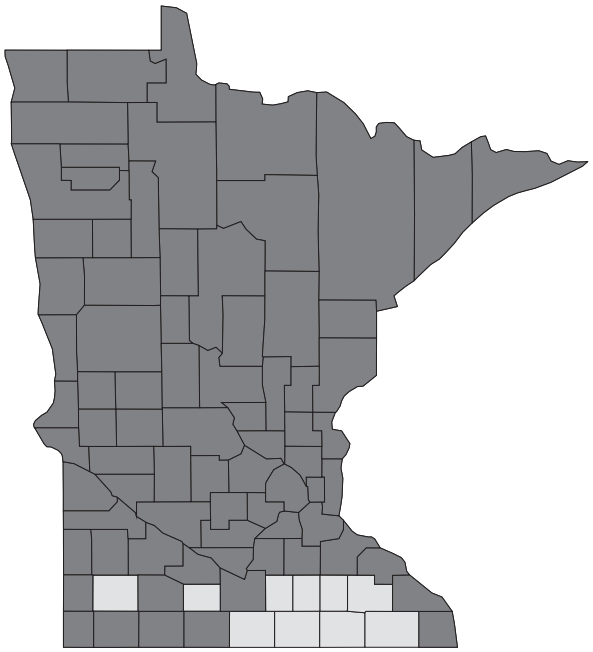
- Your application cannot be processed without the initial month's premium payment.
- Mail the completed application including additional documentation or written proof required to UCare, PO Box 52, Minneapolis, MN, 55440-9682 or fax it to 612-617-3898.
- This application will become a part of your contract.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

Effective date of coverage

- Applying during Open Enrollment (November 1, 2025 – January 15, 2026): Your application must be received by December 15, 2025 in order to begin coverage on January 1, 2026.
- 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 ☐ Male ☐ Female ☐ Choose not to disclose	Date of birth	Coverage date	Social Security number[1]

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? ☐ Single ☐ Married	Tobacco user[2] ☐ 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, PO 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, 2025 – January 15, 2026)
Your effective date of coverage is January 1, 2026. Your application and initial premium must be received by the 15th of December in order to begin coverage on January 1, 2026 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, 2025 – January 15, 2026). 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 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.

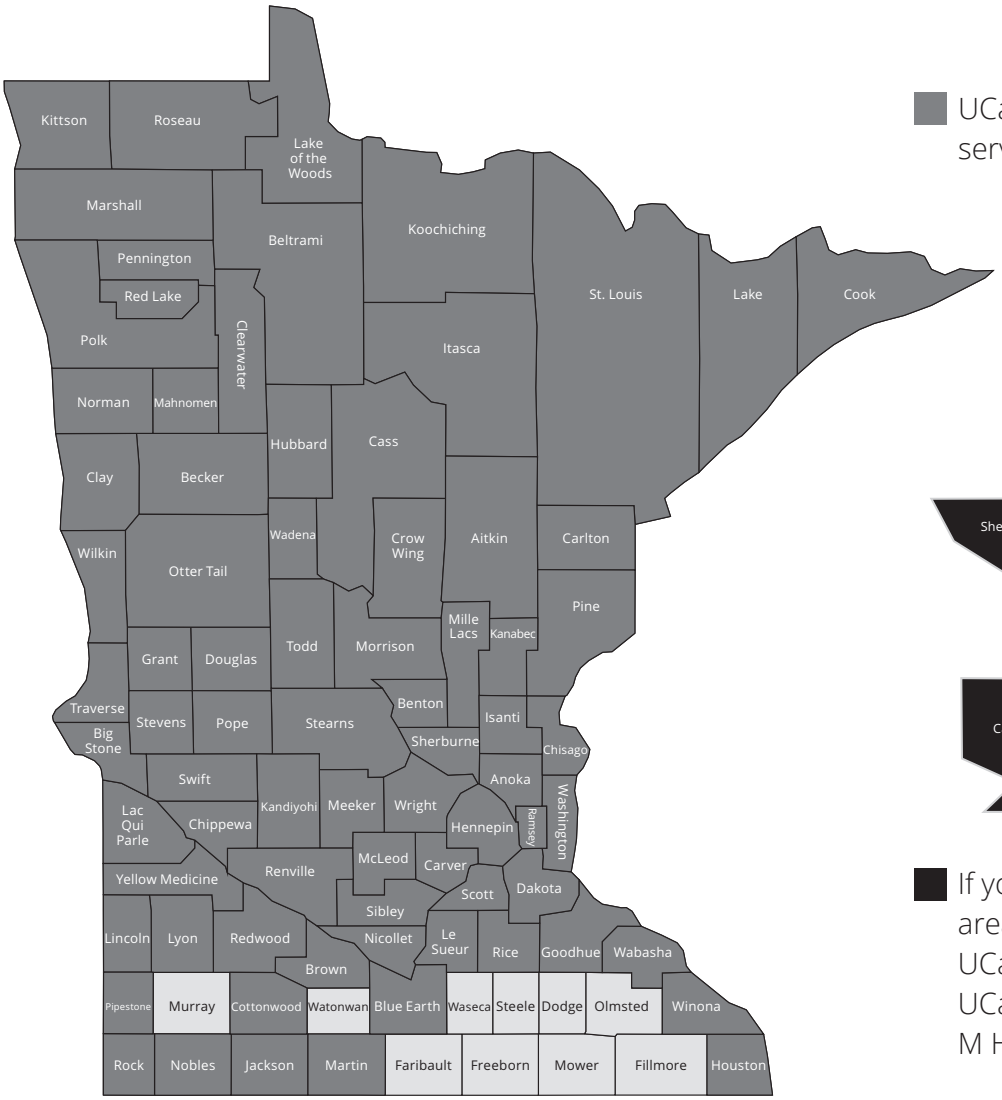
By completing this enrollment application I attest that I am a resident of a Minnesota county listed above at the time of completing this form.

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 12



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/family deductible	$10,600/$21,200	$8,600/$17,200	$7,500/$15,000
Individual/family out-of-pocket maximum	$10,600/$21,200	$10,150/$20,300	$10,150/$20,300
Default coinsurance	0%	45%	35%
Preventive care	No charge	No charge	No charge
Primary care office visits, including mental health and substance use services	$30 copay for first three eligible office visits, then 0% after deductible	$60 copay, unlimited	$60 copay for first three eligible office visits, then 35% after deductible
Specialist office visits	0% after deductible	$120 copay, unlimited	$60 copay for first three eligible office visits, then 35% after deductible
Urgent care	0% after deductible	$80 copay, unlimited	$60 copay for first three eligible office visits, then 35% after deductible
Convenience care	No charge	No charge	No charge
Online care	No charge	No charge	No charge
Emergency room	0% after deductible	45% after deductible	35% after deductible
Tier 1 prescription drugs	0% after deductible	$20 copay for up to 30-day supply	$20 copay for up to 30-day supply
Tier 2 prescription drugs	0% after deductible	$30 copay for up to 30-day supply	$30 copay for up to 30-day supply
Tier 3 prescription drugs	0% after deductible	$200 copay for up to 30-day supply	$200 copay for up to 30-day supply

*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	Gold
Individual/family deductible	$4,250/$8,500	$1,500/$3,000
Individual/family out-of-pocket maximum	$9,600/$19,200	$8,500/$17,000
Default coinsurance	30%	20%
Preventive care	No charge	No charge
Primary care office visits, including mental health and substance use services	$35 copay or $0 if telehealth, unlimited	No charge
Specialist office visits	$85 copay, unlimited	$40 copay, unlimited
Urgent care	$50 copay, unlimited	$40 copay, unlimited
Convenience care	No charge	No charge
Online care	No charge	No charge
Emergency room	$500 copay first visit, then 30% after deductible	$500 copay first visit, then 20% after deductible
Tier 1 prescription drugs	$15 copay for up to 30-day supply	$10 copay for up to 30-day supply
Tier 2 prescription drugs	$25 copay for up to 30-day supply	$20 copay for up to 30-day supply
Tier 3 prescription drugs	$175 copay for up to 30-day supply	$125 copay for up to 30-day supply

Copay plans — UCare Individual and Family Plans

	UCare Easy Compare Bronze**	UCare Easy Compare Silver and Rx Copay**	UCare Easy Compare Gold and Rx Copay**
Individual/family deductible	$7,500/$15,000	$4,500/$9,000	$2,000/$4,000
Individual/family out-of-pocket maximum	$9,700/$19,400	$9,200/$18,400	$8,200/$16,400
Default coinsurance	50%	30%	20%
Preventive care	No charge	No charge	No charge
Primary care office visits, including mental health and substance use services	$0 copay for first four eligible office visits, then $60 copay, unlimited	$0 copay for first four eligible office visits, then $40 copay, unlimited	$0 copay for first four eligible office visits, then $30 copay, unlimited
Specialist office visits	$140 copay, unlimited	$100 copay, unlimited	$70 copay, unlimited
Urgent care	$100 copay, unlimited	$75 copay, unlimited	$50 copay, unlimited
Convenience care	$0 copay for first four eligible office visits, then $60 copay, unlimited	$0 copay for first four eligible office visits, then $40 copay, unlimited	$0 copay for first four eligible office visits, then $30 copay, unlimited
Online care	$0 copay for first four visits, then $60 copay, unlimited	$0 copay for first four visits, then $40 copay, unlimited	$0 copay for first four visits, then $30 copay, unlimited
Emergency room	50% after deductible	30% after deductible	20% after deductible
Tier 1 prescription drugs	$25 copay for up to 30-day supply	$20 copay for up to 30-day supply	$15 copay for up to 30-day supply
Tier 2 prescription drugs	50% coinsurance after deductible	$40 copay for up to 30-day supply	$30 copay for up to 30-day supply
Tier 3 prescription drugs	50% coinsurance after deductible	$120 copay for up to 30-day supply	$90 copay for up to 30-day supply

**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/family deductible	$8,500/$17,000	$3,500/$7,000
Individual/family out-of-pocket limit	$8,500/$17,000	$7,500/$15,000
Default coinsurance	0%	25%
Preventive care	No charge	No charge
	After the deductible	
Primary care office visits, including mental health and substance use services	0% coinsurance	25% coinsurance
Specialist office visits	0% coinsurance	25% coinsurance
Urgent care	0% coinsurance	25% coinsurance
Convenience care	0% coinsurance	25% coinsurance
Online care	0% coinsurance	25% coinsurance
Emergency room	0% coinsurance	25% coinsurance
Tier 1 prescription drugs	0% coinsurance	25% coinsurance
Tier 2 prescription drugs	0% coinsurance	25% coinsurance
Tier 3 prescription drugs	0% coinsurance	25% coinsurance

4. Make your plan selection.

Copy plans

UCare Individual & Family Plan

- ☐ Core*
- ☐ Bronze Access**
- ☐ Bronze
- ☐ Easy Compare Bronze**
- ☐ Silver
- ☐ Easy Compare Silver and Rx Copay**
- ☐ Gold
- ☐ Easy Compare Gold and Rx Copay**

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 Availability

ATTENTION: Free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 612-676-3200/1-800-203-7225 (TTY 612-676-6810/1-800-688-2534).

ልብ ይበሉ:- የአማርኛ ቋንቋ የሚናገሩ ከሆነ፣ ነፃ የቋንቋ ድጋፍ አገልግሎት ለእርስዎ ቀርቦልዎታል። ተደራሽ በሆኑ ቅርፀቶች መረጃዎችን ለማቅረብ ተገቢ የሆኑ አጋዥ ድጋፍ ሰጪ መሳሪያዎች እና አገልግሎቶችም እንዲሁ በነፃ ቀርበዋል። በ 612-676-3200/1-800-203-7225 (TTY 612-676-6810/1-800-688-2534) **ይደውሉ.**

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر أيضًا المساعدات والخدمات المساعدة الإضافية لتوفير المعلومات بتنسيقات يسهل الوصول إليها مجانًا. يمكنك الاتصال على الرقم 612-676-3200/1-800-203-7225 (TTY 612-676-6810/1-800-688-2534).

សូមជ្រាបជាដំណឹង៖ ប្រសិនបើអ្នកនិយាយភាសា ខ្មែរ សេវាកម្មជំនួយភាសាឥតគិតថ្លៃអាចត្រូវបានផ្តល់ជូនសម្រាប់អ្នក។ ជំនួយ និងសេវាជំនួយសមស្របដើម្បីផ្តល់ព័ត៌មានក្នុងទម្រង់ដែលអាចចូលប្រើបានក៏ត្រូវបានផ្តល់ជូនដោយឥតគិតថ្លៃផងដែរ។ ទូរសព្ទទៅលេខ 612-676-3200/ 1-800-203-7225 (TTY 612-676-6810/1-800-688-2534)។

請注意：如果您講粵語，可得免費語言協助服務。還可免費提供適當的輔助工具和服務，能以無障礙格式提供資訊。請致電 612-676-3200/1-800-203-7225 (聽障專線 612-676-6810/1-800-688-2534)。

请注意：如果您说普通话，我们可为您免费提供语言协助服务。此外，我们还免费提供适当的辅助设备和服务，以无障碍格式提供信息。请致电 612-676-3200/1-800-203-7225 (TTY 612-676-6810/1-800-688-2534)。

ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et des services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 612-676-3200/1-800-203-7225 (ATS 612-676-6810/1-800-688-2534).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 612-676-3200/ 1-800-203-7225 (TTY 612-676-6810/1-800-688-2534) an.

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपकेललए नन: शुल्क भाषा सहायता सेवाएंउपलब्ध हैं। सुलभ फॉर्मेट मेंजानकारी प्रदान करनेकेललए उपयुक्त सहायक साधन और सेवाएंभी नन: शुल्क उपलब्ध हैं। 612-676-3200/1-800-203-7225 (TTY 612-676-6810/1-800-688-2534) पर कॉल करें।

TSWM SEEB: Yog tias koj hais tau lus Hmoob, ces yuav muaj kev pab cuam txhais lus pub dawb rau koj siv. Kuj tseem muaj cov kev pab txhawb ntxiv thiab cov kev pab cuam uas tsim nyog los mus muab cov ntaub ntawv qhia paub nyob rau cov qauv uas nkag siv tau dawb thiab. Hu rau 612-676-3200/1-800-203-7225 (TTY 612-676-6810/1-800-688-2534).

ໝາຍເຫດ: ການບໍລິການທາງດ້ານພາສາແມ່ນຟຣີພ້ອມໃຫ້ບໍລິການແກ່ທ່ານ. ນອກນັ້ນ, ຍັງມີການບໍລິການຊ່ວຍເຫຼືອ ແລະ ການບໍລິການເສີມທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ທ່ານເຂົ້າເຖິງໄດ້ຟຣີອີກນຳ. ໂທ 612-676-3200/1-800-203-7225 (TTY 612-676-6810/1-800-688-2534).

HUBACHIISA: Afaan Oromo kan dubbattan yoo ta'e, tajaajila gargaarsa afaanii bilisaan ni argattu. Odeeffannoo bifa dhaqqabamaa ta’een dhiheessuf, gargaarsii fi tajaajiloonni dabalataa mijatoo ta’anis bilisaan ni kennamu. Bilbilaa 612-676-3200/1-800-203-7225 (TTY 612-676-6810/1-800-688-2534).

ВНИМАНИЕ: Если вы говорите на русском языке, вам доступны бесплатные услуги языковой помощи. Соответствующие вспомогательные средства и услуги по предоставлению информации в других форматах также можно получить бесплатно. Позвоните по номеру 612-676-3200/1-800-203-7225 (TTY 612-676-6810/1-800-688-2534).

FIIRO GAAR AH: Haddii aad ku hadasho Af-Soomaali, adeegyada caawimaada luuqadda ee bilaashka ah ayaa laguu heli karaa. Kaalmooyinka iyo adeegyada dheeraadka ah ee kugu habboon si macluumaadka laguugu siiyo qaabab la isticmaali karo ayaa sidoo kale laguu heli karaa weliba si lacag la'aan ah. Wac 612-676-3200/1-800-203-7225 (TTY 612-676-6810/ 1-800-688-2534).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También disponemos de ayudas y servicios auxiliares adecuados de forma gratuita para facilitar información en formatos accesibles. Llame al 612-676-3200/1-800-203-7225 (TTY 612-676-6810/1-800-688-2534).

PAUNAWA: Kung nagsasalita ka ng Tagalog, may magagamit kang mga libreng serbisyo ng tulong sa wika. Mayroon ding mga naaangkop na karagdagang pantulong at serbisyo para makapagbigay ng impormasyon sa mga accessible na format na magagamit nang libre. Tumawag sa 612-676-3200/1-800-203-7225 (TTY 612-676-6810/1-800-688-2534).

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi có sẵn dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Ngoài ra, cũng có sẵn các hỗ trợ và dịch vụ phụ trợ thích hợp miễn phí nhằm cung cấp thông tin ở các định dạng có thể truy cập. Gọi 612-676-3200/1-800-203-7225 (TTY 612-676-6810/ 1-800-688-2534).