MEDICAL MUTUAL OF OHIO®

Employee Application/Change Form For Individuals in Groups with 20+ Eligible Employees

INSURANCE WAIVER

COMPLETE THE WAIVER SECTION BELOW ONLY if you do not want any coverage or want to waive some of the coverage options.

A. Waived coverages: I do not want (Check all that apply)

☐ Self: ☐ Health ☐ Drug ☐ Dental ☐ Vision through Medical Mutual®

☐ Dependent: ☐ Health ☐ Drug ☐ Dental ☐ Vision through Medical Mutual for the following spouse and/or dependent(s) only:

1 _____ 2 _____ 3 _____ 4 _____ 5 _____

Please indicate reason for waiving coverage:

☐ No coverage

☐ Employee/dependent has coverage. Insurance company name: _____

B. Current health coverage status: I have: (Check one)

☐ No coverage

☐ Other coverage: _____

☐ Coverage through my spouse's employer. Company name: _____

C. Terms and Declarations:

I understand that if I check any box in Question A of this Waiver I am choosing not to have those persons covered under the health insurance designated, and any later application for enrollment and acceptance will be subject to all underwriting requirements.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you will be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

I have read and understand the above terms:

Current Employer: _____

Print Employee Name: _____ Employee Social Security Number: _____

Print Spouse Name: _____ Spouse Social Security Number: _____

Employee Signature: _____ Date: _____

WARNING: If you or your family members are covered by more than one healthcare plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and hospitals, and it may be impossible to comply with both plans at the same time. Before you enroll in this plan, read all of the rules very carefully and compare them with the rules of any other plan that covers you or your family. (Ohio Admin. Code Section 3901-1-56)

Employee Name	Group/Company Name
Social Security #	Group #/Section # (required)

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1. ACTION REQUESTED

☐ New Policy Application or **☐ COBRA/Continuation**

Requested Effective Date: _____ (Optional)

Select Coverage: (Check all that apply)

- ☐ Health Product Name: _____
- ☐ Drug Product Name: _____
- ☐ Dental Product Name: _____
- ☐ Vision Product Name: _____
- ☐ Life Complete Life and Disability Benefit section

☐ Policy Change

Requested Date of Change: _____ (Optional)

Action: (Check the type of change)

- ☐ Address change (Enter new address in Section 2)
- ☐ Add dependent to policy (List dependent(s) in Section 3)
- ☐ Delete dependent from policy (List dependent(s) in Section 3)
- ☐ Add spouse due to marriage. Date Married: _____(List spouse in Section 3)
- ☐ Name change. Former Name: _____
- ☐ Cancel coverage
- ☐ Other

2. EMPLOYEE INFORMATION

Last Name	First Name	MI	Social Security#	Date of Birth (MM/DD/YYYY)	Gender ☐ M ☐ F

Employment Status	Marital Status		
☐ Active, Full Time Date of (Re)Hire: _____	☐ Single ☐ Married, Date Married: _____ ☐ Divorced ☐ Separated ☐ Widowed		
☐ Retired	Job Title		Department #
☐ COBRA, Expiration Date: _____			
Home Address	City	State	Zip Code
Email Address	Home Phone Number	Primary Care Physician (HMO and Select Only)	

3. COVERED DEPENDENTS

Relationship	First Name	Last Name (if different)	Social Security #	Date of Birth	Gender	Primary Care Physician (HMO and Select only)
Spouse					☐ M ☐ F	
☐ Child[1] ☐ Adopted[2] ☐ Stepchild[1] ☐ Other[2]					☐ M ☐ F	
☐ Child[1] ☐ Adopted[2] ☐ Stepchild[1] ☐ Other[2]					☐ M ☐ F	
☐ Child[1] ☐ Adopted[2] ☐ Stepchild[1] ☐ Other[2]					☐ M ☐ F	
☐ Child[1] ☐ Adopted[2] ☐ Stepchild[1] ☐ Other[2]					☐ M ☐ F	

[1] If over limiting age, Student or Disability Certification form must be attached to this application
[2] Legal Documentation (court decree, guardianship papers, etc.) must be attached to this application

4. OTHER COVERAGE

Medicare Information Are you or any dependent covered by Medicare? ☐ Yes ☐ No If yes, please complete the section below:

Policyholder Name	Medicare Number	Part A Effective Date	Part B Effective Date	Reason for Medicare
				☐ Age ☐ End Stage Renal ☐ Disability, Indicate Reason: _____
				☐ Age ☐ End Stage Renal ☐ Disability, Indicate Reason: _____

Continuing Coverage (other than Medicare) Are you or any dependent keeping other health insurance coverage? ☐ Yes ☐ No If yes, please complete the section below:

Policyholder Name	Name and Address of Insurance Company	Policy Number	Effective Date	Coverage Type	Work Status	Policy Type
				☐ Medical ☐ Dental ☐ Hospital Only ☐ Vision ☐ Prescription Drug	☐ Active ☐ Retired	☐ Single ☐ Family

Prior or Ending Coverage Do you or any dependent have any prior or ending health insurance? ☐ Yes ☐ No If yes, please complete the section below:

- What date did your most recent health insurance become effective? _____
- What date did/will this health insurance terminate? _____
- Please indicate the carrier name for the above health insurance: _____

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5. MEDICAL HEALTH QUESTIONNAIRE

A. MEDICAL CONDITIONS

Have you or any listed dependent been treated for, diagnosed as having, or have been recommended for future surgery, diagnostic testing or medical treatment or thought you should seek medical advice for any of the following conditions? If yes, explain in 5c.

Y N		Y N		Y N		Y N	
1. ☐ ☐	AIDS/AIDS-Related Complex (Diagnosed with)	5. ☐ ☐	Cancer	10. ☐ ☐	Kidney Disease	15. ☐ ☐	Spinal/Disc Disorder
2. ☐ ☐	Alcohol/Drug Dependency	6. ☐ ☐	Circulatory Disorder	11. ☐ ☐	Lung Disease	16. ☐ ☐	Transplant
3. ☐ ☐	Auto-Immune Disorder	7. ☐ ☐	Diabetes/Endocrine	12. ☐ ☐	Mental Health Disorder	17. ☐ ☐	Smoker
4. ☐ ☐	Blood/Clotting Disorder	8. ☐ ☐	Heart Disease	13. ☐ ☐	Muscle/Skeletal Disorder	18. ☐ ☐	Other_____
		9. ☐ ☐	Infertility	14. ☐ ☐	Nervous System Disorder		

B. MEDICAL QUESTIONS

Y N

1. ☐ ☐ Have you or any dependent been hospitalized, had surgery, been advised to have surgery or seek treatment for any medical condition? (Explain in 5c)
2. ☐ ☐ Are you or any dependent currently taking any prescription or over the counter medications? (Explain in 5c)
3. ☐ ☐ Are you or any dependent currently pregnant?

If yes: Name:_____ Due Date:_____ Is this pregnancy considered high risk? ☐ Y ☐ N

C. EXPLANATION (Explain all *yes* responses from Medical Conditions and Medical Questions here)

Name	Diagnosis	Treatment Date (From-To)	Treatment/Medication/Dosage (Be specific)	Recovered Y N
John Doe	*Skin Cancer*	*10/2005-3/2007*	*Radiation/Medication Xxxxxxxx*	☑ ☐
				☐ ☐
				☐ ☐
				☐ ☐
				☐ ☐
				☐ ☐
				☐ ☐

Attach a separate sheet if additional space is required.

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Employee Name	Group/Company Name
Social Security #	Group #/Section # (required)

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6. ABOUT YOUR NEEDS

If you have a special language or other cultural need that may affect the administration of your health plan or healthcare delivery, please indicate below so that Medical Mutual may better assist you:

Y	N	
☐	☐	Hearing-impaired (Require use of TDD/TYY or other means of communication)
☐	☐	Vision-impaired (Require audio communication or large print document)
☐	☐	Speak a primary language other than English (Require interpretive services) please list language: _____
☐	☐	Other cultural need/preference: _____

7. PRE-EXISTING CONDITION NOTICE

The following information is attached to and incorporated into your application to Medical Mutual of Ohio:

This plan imposes a pre-existing condition exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within no more than a six-month "look-back" period. Generally, this look-back period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the look-back period ends on the day before the waiting period begins. The pre-existing condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 30 days after birth, adoption, or placement for adoption. This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the maximum 12-month (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you having creditable coverage. Please contact us if you need help demonstrating creditable coverage. All questions about the pre-existing condition exclusion and creditable coverage should be directed to CustomerService@MedMutual.com or your sales representative.

8. LIFE AND DISABILITY BENEFITS

A. COVERAGE SELECTION

Your group insurance program provided by Consumers Life Insurance Company may not include all the benefits listed below. Ask your employer for the details about the benefits available to you, your cost, if any, and whether you will be required to submit evidence of insurability.

Y	N	Basic Coverage(s)	Add/Delete	Total Amount of Coverage Applied
☐	☐	Basic Life		
☐	☐	Basic AD&D		
☐	☐	Dependent Life		
☐	☐	Short Term Disability		
☐	☐	Long Term Disability		
☐	☐	Supplemental Life		
☐	☐	Supplemental AD&D		

B. CLASS AND SALARY INFORMATION

Class:	Earnings: $ _____ ☐ Weekly ☐ Monthy ☐ Annual	Occupation/Job Title:

C. BENEFICIARY DESIGNATION

(For Employee Only: Must be completed if you have applied for Life or AD&D insurance). If two or more primary beneficiaries are named, and you do not list benefit percentages, proceeds will be paid in equal shares to the named primary beneficiaries who survive you. If no primary beneficiary survives you, proceeds will be paid to the contingent beneficiary(ies). If you list benefit percentages, the total must equal 100%. (Employee is the beneficiary of proceeds from spouse or child coverage.)

Last Name	First Name	Date of Birth	Relationship	Benefit %
Primary:				
Primary:				
Contingent:				
Contingent:				

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Employee Name	Group/Company Name
Social Security #	Group #/Section # (required)

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9. TERMS AND CONDITIONS

I hereby apply to the carrier(s) offering the coverage indicated on this application.

I authorize: (1) payroll deduction(s) and remittance of any required contribution for coverage to Medical Mutual (MMO), Consumers Life Insurance Company (CLIC), Medical Health Insuring Corporation of Ohio (MHICO) and/or any affiliates or divisions of Medical Mutual; (2) release of information, without limitation, from any medical/medically-related facility, government agency or person: (a) to evaluate this application for up to 30 months from the date of this application; (b) to adjudicate claims submitted on behalf of me or my dependents as long as I am covered under this policy; (c) for utilization review programs to monitor health services or quality improvement activities; (d) for credentialing purposes. I authorize the applicable carrier to provide a photocopy of this release to any physician or medical institution to obtain records for the purposes stated above.

I understand: (1) any untrue or incomplete information, statements or answers on this application (whether intentional or not), can result in denial of a claim or rescission of coverage and may subject me to legal action by the carrier(s); (2) to be eligible for health coverage, I must be an active full time employee as defined by the policy; (3) if coverage is issued, it will be based on full reliance on the information contained in this application.

I understand and agree that no agent or broker has the authority: (1) to bind MMO and/or CLIC by making promises regarding eligibility, benefits, or the issuance of a policy; (2) to waive any answer or any portion of any answer to any question on this application or any information MMO and/or CLIC requests; (3) approve coverage; (4) make or alter any contract on behalf of MMO and/or CLIC; or (5) waive or alter any of MMO and/or CLIC's other rights or requirements. All contract terms must be in writing and signed or accepted in writing by an authorized representative of MMO and/or CLIC to be binding on MMO and/or CLIC.

I understand that, if my personal health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

I understand that I have a right to revoke this authorization at any time. My revocation must be in writing. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my personal health information have acted in reliance upon this authorization.

I understand and acknowledge that this authorization extends to all medical records, including records which may contain information regarding treatment for physical and mental illness, alcohol/drug abuse and/or HIV - AIDS test results or diagnosis. I expressly consent to the release of such information.

If you write in HMO Health Ohio as the benefit you want in Section 1, the following provisions apply: 1. The HMO restricts enrollee access to health care providers. NO benefits are payable for covered services which are not provided, arranged and authorized by a Plan Physician and approved by the Medical Director. This applies to all covered services which are not provided, arranged and authorized by a Plan Physician and approved by the Medical Director. This applies to all covered services except Emergency Services. The HMO will furnish you with a list of plan physicians and plan facilities upon enrollment and/or request. 2. Right of Cancellation: If you are obligated to share in the cost of this coverage, you may cancel this application within 72 hours after you have signed this application. Cancellation will occur when written notice is given to MHICO. Notice of cancellation shall be considered given when you mail a letter to MHICO.

I have read all of the statements contained in this application, and declare by signing this application that I am an active, eligible, compensated, full-time employee and that the information I have provided is true and complete to the best of my knowledge. I understand that I should not cancel any current health insurance coverage until I receive an approval letter and insurance certificate from MMO and/or CLIC.

Employee Signature	Date	Your Spouse's Signature (If applying for coverage)	Date

WARNING: Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against any insurer, submits any application or files a claim containing a false or deceptive statement is guilty of insurance fraud. (Ohio Revised Code Section 3999.22)

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