Employee Indemnity Benefit Application/Change Form

MEDMUTUAL LIFE®
A Medical Mutual Company

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

Section I: ACTION REQUIRED

Check type of change:

- ☐ Enroll in the coverage selected in this Application
- ☐ Decline this opportunity to participate
- ☐ Add dependent to the coverage (dependents in section II)
- ☐ Delete dependent from coverage (list dependents in section II)
- ☐ Add spouse due to marriage (list spouse in section II) Date married: _____
- ☐ Name change (list new name in section II) Former name: _____
- ☐ Cancel coverage
- ☐ Other (description)_____

Section II: APPLICANT INFORMATION

Last Name	First Name	MI
Permanent Residence	City	

County	State	Zip Code	Best Contact # ( )	Alternate # ( )

E-mail Address	Marital Status: ☐ Single ☐ Married

Employment Status

☐ Active, **Full Time Date of (Re)Hire:** _____

Relationship	First Name, MI (and last name, if different)	Social Security Number[2]	Birth Date	Gender	Tobacco User[3]
Self				☐ M ☐ F	☐ **Y** ☐ **N**
Spouse				☐ M ☐ F	☐ **Y** ☐ **N**
Domestic Partner[1]				☐ M ☐ F	☐ **Y** ☐ **N**
Dependent Child[2]				☐ M ☐ F	☐ **Y** ☐ **N**
Dependent Child[2]				☐ M ☐ F	☐ **Y** ☐ **N**
Dependent Child[2]				☐ M ☐ F	☐ **Y** ☐ **N**

[1]Refer to Section V, Terms and Conditions, for domestic partner eligibility requirements.

[2]Providing Social Security Number for Employee & Spouse/Domestic Partner will maximize claims accuracy and expedite processing. If more than three Dependent Children, please attach additional sheet with their information.

[3]Tobacco User definition – the legal use (other than religious or ceremonial) of any tobacco product on average four or more times per week within no longer than the last six months.

WARNING: Any person who, with the intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

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Section III: PRODUCTS

Critical Illness, Accident and Hospital Benefits

Your group insurance provided by MedMutual Life may not include all the benefits listed below. Ask your employer for the details about the benefits available to you and your cost (if any).

Group Accident

☐ Employee Only
☐ Employee + Spouse
☐ Employee + Child
☐ Employee + Spouse + Children

Group Critical Illness
Choose Employee Benefit Level:

☐ $10,000 ☐ $20,000 ☐ $30,000
(if requesting coverage for spouse or children, the basic benefit is 50% of the employee)

☐ Employee Only
☐ Employee + Spouse
☐ Employee + Child
☐ Employee + Spouse + Children

Section IV: PRE-EXISTING CONDITION LIMITATION NOTICE

MedMutual Life will not cover a condition which begins in the 12 months after your effective date and is caused by, contributed to or results from a Pre-existing Condition.

Pre-existing Condition is defined as a sickness or injury for which you, within the 3 months prior to your effective date of coverage:

1. received medical treatment, consultation, care or services, including diagnostic measures; or
2. had taken prescribed drugs or medicines.

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Section V: TERMS AND CONDITIONS

I hereby apply to MedMutual Life Insurance Company ("MedMutual Life") for the coverage indicated on this Application.

I authorize: (1) payroll deduction(s) and remittance of any required contribution for coverage to MedMutual Life, and/or any affiliates or divisions of MedMutual Life; (2) release of information, without limitation, from any medical/medically related facility, prior health insurance carrier, the Medical Information Bureau, Inc. (MIB), government agency or person to MedMutual Life and/or any affiliates or division of MedMutual Life: (a) to evaluate this application; (b) to adjudicate claims submitted on behalf of me or my dependents; and/or; (c) for credentialing purposes. I authorize MedMutual Life to provide a photocopy of this release to any physician or medical institution to obtain records for the purposes stated above. This authorization will be valid for a period of two and one-half years for the purpose of collecting information regarding this Application.

By signing below, I represent and warrant as follows: (a) I have thoroughly read and understand this Application and the questions asked herein; (b) I am solely and exclusively responsible for the truth, accuracy and completeness of all of the answers contained in this Application; (c) I have answered each and every question set forth in this Application; (d) all of my answers to each of the questions are accurate, complete and true; and (d) I did not sign a blank or partially completed Application.

I understand and agree that no agent or broker who may be assisting in the completion of this Application has any authority: (a) to waive any answer or any portion of any answer to any question on this Application or any information MedMutual Life requests; (b) to make any representation concerning benefits that is inconsistent with, or different from, any written information provided by MedMutual Life; (c) to bind MedMutual Life in any way by making any statement, promise or representation that is not set out in writing in this Application or regarding eligibility, benefits or issuance of a policy; (d) to answer any questions in, or insert any information on, this Application on my behalf; or (e) to approve coverage. All contract terms must be in writing and signed or accepted in writing by an authorized representative of MedMutual Life to be binding on MedMutual Life.

I agree that: (a) any untrue or incomplete information, statement 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 MedMutual Life; (b) to be eligible for coverage, I must be an active, full-time employee and be actively at work, as defined in the group policy(ies). If I am not actively at work on the date my coverage would become effective, my coverage will not begin until the day I return to work; (c) if coverage is issued, it will be based on full reliance on the information contained in this Application.

My dependents and I understand and agree that any information obtained will not be released by the MedMutual Life to any person or organization except to reinsuring companies, the MIB, or other persons or organizations performing health care operations or business or legal services in connection with any Application, claim, or as may be otherwise lawfully required, or as we may further authorize. If a Consumer Reporting Agency is used, I (we) may request to be interviewed in connection with the preparation of the report. Once personal and health (including medical, dental, and pharmacy) information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient, and the information may not be protected by federal and state privacy requirements. A copy of this authorization request is available to me or my legal representative upon written request. A photographic copy of this authorization shall be as valid as the original. This authorization shall be valid for a period of two and one-half years. I have the right to revoke this authorization at any time. To revoke this authorization, I must do so in writing and send my written revocation to MedMutual Life's Privacy Office. The revocation will not apply to information that has already been released in response to this authorization. The revocation may adversely affect my Application, a claim or a pending insurance action. The revocation will become effective after it is received by MedMutual Life's Privacy Office.

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.

I am signing this Application on my own behalf and on behalf of all listed dependents. An unaltered copy of this authorization is as valid as the original. I understand that I should not cancel any current insurance coverage until I receive an approval letter and insurance certificate/policy from MedMutual Life.

If I am applying for coverage for my domestic partner, I represent and warrant that I and my domestic partner: 1) cohabit and reside together in the same residence and have done so for at least six months and intend to do so indefinitely; 2) are engaged in an exclusive and committed relationship and are financially interdependent; 3) are both at least 18 years of age and are each other's sole domestic partner; 4) are not married or separated from anyone else; 5) have not had another domestic partner within six months of establishing the current domestic partnership; 6) are not related by blood; and 7) are not in this relationship solely for the purpose of obtaining insurance benefits.

Employee Signature: _____ Date: _____

WARNING: Any person who, with intent to defraud or knowing that he is facilitating fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. (Ohio Revised Code Section 3999.21).

Multi-Language Interpreter Services & Nondiscrimination Notice

This document notifies individuals of how to seek assistance if they speak a language other than English.

Spanish

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-382-5729 (TTY: 711).

Chinese

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 1-800-382-5729 (TTY: 711)。

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-382-5729 (TTY: 711).

Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-382-5729 رقم هاتف الصم والبكم 711).

Pennsylvania Dutch

Wann du Deitsch schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-382-5729 (TTY: 711).

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-382-5729 (телетайп: 711).

French

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-382-5729 (ATS: 711).

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-382-5729 (TTY: 711).

Navajo

Díí baa akó nínízin: Díí saad bee yáníłti' go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-800-382-5729 (TTY: 711).

Oromo

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-382-5729 (TTY: 711).

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-382-5729 (TTY: 711)번으로 전화해 주십시오.

Italian

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-382-5729 (TTY: 711).

Japanese

注意事項:日本語を話される場合、無料の言語支援をご利用いただけます。1-800-382-5729 (TTY: 711) まで、お電話にてご連絡ください。

Dutch

AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-800-382-5729 (TTY: 711).

Ukrainian

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-382-5729 (телетайп: 711).

Romanian

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-382-5729 (TTY: 711).

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-382-5729 (TTY: 711).

Please Note: Products marketed by Medical Mutual may be underwritten by one of its subsidiaries, such as Medical Health Insuring Corporation of Ohio or MedMutual Life Insurance Company.

Order Number: Z8188-MCA R4/19
Dept of Ins. Filing Number: Z8188-MCA R9/16

QUESTIONS ABOUT YOUR BENEFITS OR OTHER INQUIRIES ABOUT YOUR HEALTH INSURANCE SHOULD BE DIRECTED TO MEDICAL MUTUAL'S CUSTOMER CARE DEPARTMENT AT 1-800-382-5729.

Nondiscrimination Notice

Medical Mutual of Ohio complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex in its operation of health programs and activities. Medical Mutual does not exclude people or treat them differently because of race, color, national origin, age, disability or sex in its operation of health programs and activities.

- Medical Mutual provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, etc.).
- Medical Mutual 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 or if you believe Medical Mutual failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, with respect to your health care benefits or services, you can submit a written complaint to the person listed below. Please include as much detail as possible in your written complaint to allow us to effectively research and respond.

Civil Rights Coordinator
Medical Mutual of Ohio
2060 East Ninth Street
Cleveland, OH 44115-1355
MZ: 01-10-1900

Email: CivilRightsCoordinator@MedMutual.com

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:
  ocrportal.hhs.gov/ocr/portal/lobby.jsf
- By mail at:
  U.S. Department of Health and Human Services
  200 Independence Avenue, SW Room 509F
  HHH Building
  Washington, DC 20201-0004
- By phone at:
  1-800-368-1019 (TDD: 1-800-537-7697)
- Complaint forms are available at:
  hhs.gov/ocr/office/file/index.html

Products marketed by Medical Mutual may be underwritten by one of its subsidiaries, such as Medical Health Insuring Corporation of Ohio or MedMutual Life Insurance Company.