





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 and	y coverage or want to waive some o	f the coverage options.
A. Waived coverages: I do not want (Check all that apply) Self: Health Drug Dental Vision through M Life/Disability through Consumers Life Insuranc Dependent: Health Drug Dental Vision through M	e Company	se and/or dependent(s) only:
1 2 3		
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 Waive health insurance designated, and any later application for enrequirements.		
If you are declining enrollment for yourself or your dependents (incoming may in the future be able to enroll yourself or your dependents in the your other coverage ends. In addition, if you have a new dependents adoption, you will be able to enroll yourself and your dependents marriage, birth, adoption or placement for adoption.	is plan, provided that you request endent as a result of marriage, birth,	rollment within 31 days after , adoption or placement for
I have read and understand the above terms:		
Current Employer:	MMO Group Number:	
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)





□ New Policy Application or □ COBRA/Continuation					□ Policy (Chang	e					
• •				Marital Sta □ Single	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:							
☐ COBRA, Expiration Da	ite:			City					State		Zip Code	
				•							-	
Email Address				Home Pho	ne Number				Primary 0	Care Physici	an (HMO and Se	elect Only)
3. COVERED DI	EPENDENT	S										
Relationship	First Name	La	ast Name (if d	lifferent)	Date of B	irth	Social Sec	curity #	Gender	Primary Ca	re Physician (нм) and Select only)
Spouse									□ M □ F			
☐ Child¹ ☐ Adopted² ☐ Stepchild¹ ☐ Other²									□ M □ F			
☐ Child¹ ☐ Adopted²									□М			
☐ Stepchild¹ ☐ Other² ☐ Child¹ ☐ Adopted²									□ F			
☐ Stepchild¹ ☐ Other² ☐ Child¹ ☐ Adopted²									□ F			
☐ Stepchild¹ ☐ Other²									□F			
¹ If over limiting age, Studer ² Legal Documentation (cou						n						
4. OTHER COVE	ERAGE											
Medicare Information	Are you or any	dependent	covered by N	/ledicare?	☐ Yes ☐	l No	If yes, plea	ise comp	olete the sec	ction below:		
Policyholder Name	Medicar	e Number	Part A Effe	ctive Date	Part B	Effect	ive Date	Reason	for Medica	ire		
								-	☐ End Stag pility, Indicate			
					☐ Age ☐ End Stage Renal ☐ Disability, Indicate Reason:							
Continuing Coverage (o	ther than Medic	are) Are y	ou or any dep	endent keep	ing other he	alth in	surance cov	verage?	□ Yes □ N	lo If yes, ple	ase complete the	section below:
Policyholder Name	Name an	d Address o	of Insurance (Company	Policy Num	ber	Effective D	ate C	overage Typ	16	Work Status	Policy Type
									□ Medical [□ Hospital On □ Prescription	ly 🗆 Vision	☐ Active ☐ Retired	☐ Single ☐ Family
Prior or Ending Coverag	Je Do you or a	ny depende	nt have any p	orior or endi	ing health i	nsura	nce? 🗆 Y	es 🗆 N	No If yes,	please com	plete the section	n below:
What date did your mo	et racant haalth	incurance h	nacoma affac	tivo?			What date	Hivv/Pib	this health	insuranco to	rminato?	

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• Please indicate the carrier name for the above health insurance: _

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





5. MEDICA	AL HEALTH QUI	ESTIONNAIRE											
Have you or any I		treated for, diagnosed as h		een recommended during the last 5 years ing conditions? If yes, explain in 5c.	for future surgery, diagnostic	testing or							
Y N 1. □ □ Alcohol/l 2. □ □ Auto-Imr 3. □ □ Blood/Cl 4. □ □ Cancer 5. □ □ Circulato	otting Disorder	Y N 6. □□ Diabetes/Endoo 7. □□ Hypertension/H 8. □□ Infertility 9. □□ Kidney Disease 10. □□ Lung Disease	leart Disease	Y N 11. □ □ Depression/Mental Disorder 12. □ □ Muscle/Skeletal Disorder 13. □ □ Nervous System Disorder 14. □ □ Spinal/Disc Disorder 15. □ □ Transplant	Y N 16. □ □ Smoker 17. □ □ Stomach/Bowel 18. □ □ Other								
B. MEDICA	AL QUESTIONS												
(Explain 2. □ □ Are you 3. □ □ Has ANY	Y N 1. □ □ Have you or any dependent been hospitalized, had surgery, been advised to have surgery or seek treatment for any medical condition during the last 5 years? (Explain in 5c) 2. □ □ Are you or any dependent currently taking any prescription or over the counter medications? (Explain in 5c) 3. □ □ Has ANY PERSON TO BE COVERED ever been diagnosed as having AIDS, or an AIDS related condition or had a positive test result on an HIV test?												
,	, ,	, , ,	_Due Date:	Is this pregnancy con:	4.								
C. EXPLAN	ATION (Explain	C. EXPLANATION (Explain all yes responses from Medical Conditions and Medical Questions here)											
		an yes responses nom med	ical Conditions a	nd Medical Questions here)									
Name	Condition Number	Treatment Date (From-To)		nd Medical Questions here) tment/Medication/Dosage (Be specific)		Recovered Y N							
John Doe	Condition Number		Diagnosis/Trea			Recovered Y N							
		Treatment Date (From-To)	Diagnosis/Trea	tment/Medication/Dosage (Be specific)									
		Treatment Date (From-To)	Diagnosis/Trea	tment/Medication/Dosage (Be specific)		□/□							
		Treatment Date (From-To)	Diagnosis/Trea	tment/Medication/Dosage (Be specific)		G ∕ □							
		Treatment Date (From-To)	Diagnosis/Trea	tment/Medication/Dosage (Be specific)		□ /□							
		Treatment Date (From-To)	Diagnosis/Trea	tment/Medication/Dosage (Be specific)		□ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □							

Attach a separate sheet if additional space is required.

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





6. A	BC	וטכ	T 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	· 1	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:						
1									

7. PRE-EXISTING CONDITION NOTICE

(HMO PLANS ARE NOT SUBJECT TO PRE-EXISTING CONDITION LIMITATIONS. THEREFORE, THIS SECTION DOES NOT APPLY TO HMO PLANS.)

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.

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Employee Name	Group/Company Name
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8. CONSUMERS LIFE INSURANCE COMPANY											
A. SE	A. SELECT COVERAGE If your employer offers these additional coverages, please check the coverages which you would like to enroll:										
]]]	□ Basic Life and AD&D (Complete sections B and C below) □ Voluntary Life, Indicate Amount: \$										
B. GE	NERAL INFOR	MATION									
Class	:	Annual S	alary (Ex	cluding bonuses, ove	rtime and oth	er forms	of extra	a pay):			
ORIGI	NAL DATE OF HIRE		OCCI	JPATION/JOB TITLE							
C. BE	NEFICIARY IN	FORMATION									
eficiarie no prim	BENEFICIARY DESIGNATION: (For Employee Only: Must be completed if you have applied for life and/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 beneficiaries survives you, proceeds with 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.)										
LAS	ST NAME		FIRST	NAME	DATE OF	BIRTH		RELATIONSHIP	BENEFIT %		
Prim	ary				/	/			%		
Prim	ary				/	/			%		
Cont	ingent				/	/			%		
Cont	ingent				/	/			%		
D. V0	LUNTARY STE	PLAN OPTIONS									
Plan	Weekly Benefit	Min. Annual Salary	Plan	Weekly Benefit	Min. Annual S	alary	Plan	Weekly Benefit	Min. Annual Salary		
□ 1	\$100	\$7,430	□ 4	\$250	\$18,570		□ 7	\$400	\$29,715		
□ 2	\$150	\$11,140	□ 5	\$300	\$22,285		□ 8	\$450	\$33,430		
□ 3	\$200	\$14,860	□ 6	\$350	\$26,000		□ 9	\$500	\$37,145		

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Employee Name	Group/Company Name
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9. TERMS AND CONDITIONS

I hereby apply to the carrier(s) offering the coverage indicated on this Application. I acknowledge that by enrolling in these products, coverage is provided by the following entities (collectively referred to as "Medical Mutual"):

- Medical Mutual of Ohio® (MMO) for non-HMO health plans
- Medical Health Insuring Corporation of Ohio (MHICO) for HMO health plans
- · Consumers Life Insurance Company® (CLIC) for life, accidental death and dismemberment, and disability benefits

I authorize: (1) payroll deduction(s) and remittance of any required contribution for coverage to Medical Mutual and/or any affiliates or divisions of Medical Mutual; (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 Medical Mutual and/or any affiliates or division of Medical Mutual: (a) to evaluate this Application; (b) to adjudicate claims submitted on behalf of me or my dependents; (c) for utilization review programs to monitor health services or quality improvement activities and/or; (d) for credentialing purposes. I authorize Medical Mutual 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 have answered each and every question set forth in this Application; (c) 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 I am solely and exclusively responsible for the truth, accuracy and completeness of all of the answers contained in this 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 Medical Mutual requests; (b) to advise me that I am not obligated to disclose any condition of which I am aware concerning my health or the health of any dependent included on the Application; (c) to make any representation concerning health benefits that are inconsistent with, or different from, any written information provided by Medical Mutual; (d) to bind Medical Mutual 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; (e) to answer any questions in, or insert any information on, this Application on my behalf; or (f) to approve coverage. All contract terms must be in writing and signed or accepted in writing by an authorized representative of Medical Mutual to be binding on Medical Mutual. The applicable certificate or evidence of coverage will determine the rights and responsibilities of covered persons and will govern in the event they conflict with any benefit comparison summary or other description of the plan.

I understand and agree that I am responsible for disclosing all information required by this Application, including, but not limited to, all health conditions and diagnoses of which I am aware. I understand and agree that Medical Mutual has the exclusive right to determine whether a particular condition or diagnosis is significant, that I do not have the right to evaluate whether a condition or diagnosis should or should not be disclosed on this Application and that I am obligated to disclose even those conditions or diagnoses that I do not believe are significant or important.

I agree that: (a) any untrue or incomplete information, statement or answers on this Application (whether or not intentional), can result in denial of a claim or rescission of coverage and may subject me to legal action by Medical Mutual; (b) to be eligible for coverage, I must be an active full-time employee as defined by the policy(ies); (c) to be eligible for life and or disability income insurance, I must be actively at work as defined in the group policy. If I am not actively at work on the date my life and/or disability income coverage would become effective, my life and/or disability coverage will begin on the day I return to work; (d) 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 Medical Mutual 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 Medical Mutual'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 Medical Mutual'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 understand that if I choose HMO coverage, the HMO restricts enrollee access to health care providers. Benefits are payable only for covered services that are provided by a Network Physician, unless otherwise approved by MHICO. 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. Right of Cancellation: If you are obligated to share in the cost of the 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 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 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 insurance coverage until I receive an approval letter and insurance certificate from Medical Mutual.

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 3999.21)

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Medical Mutual of Ohio® 2060 East Ninth Street Cleveland OH 44115-1355

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