



MEDICAL MUTUAL OF OHIO®

Employee Application & Change Form

Individuals in Groups with
20+ Eligible Employees

INSTRUCTIONS

- **PRINT CLEARLY USING A BLUE OR BLACK PEN (NO HIGHLIGHTERS)**
- **NEW HIRES, LATE ENTRANTS AND DEPENDENT ADDITIONS MUST COMPLETE THE APPLICATION INCLUDING GROUP NUMBER AND MEDICAL HISTORY QUESTIONNAIRE.**
- **CHANGES TO AN EXISTING POLICY, COMPLETE ONLY AREA THAT IS CHANGING E.G.: MARRIAGE, DIVORCE, DROPPING DEPENDENTS . . .**
- **IF ENROLLING A DEPENDENT/STUDENT, A STUDENT CERTIFICATION FORM MUST BE INCLUDED WITH THE APPLICATION.**
- **IF YOU DO NOT WANT ANY COVERAGE OR IF YOU REJECT SOME OF THE COVERAGE OPTIONS BUT ACCEPT OTHERS, COMPLETE THE WAIVER AREA.**

Medical Mutual of Ohio®
Administrative Offices
2060 E. 9th Street
Cleveland, OH 44115-1355

Consumers Life Insurance Company®
Administrative Offices
2060 E. 9th Street
Cleveland, OH 44115-1355

Coverage(s) will be provided by the Companies indicated above. Healthcare benefits will be provided by Medical Mutual of Ohio.
Life/Disability Insurance will be provided by Consumers Life Insurance Company.

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

1 _____ 2 _____ 3 _____ 4 _____ 5 _____

- Life/Disability

B. Please indicate reason for waiving coverage. 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, life or disability 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 be able to enroll yourself or your dependents in this plan if: (1) you or your dependents lose eligibility for that other coverage or reach the plan's lifetime benefit maximum; or (2) the employer stops contributing towards you or your dependents' other coverage. However, you must request enrollment within 31 days after the applicable event occurs (other coverage ends, lifetime maximum is met, or employer's contribution ends). If you or your dependent either become eligible for premium assistance or lose eligibility for coverage under the State Children's Health Insurance Program (SCHIP), you will also be able to enroll in this plan. However, you must request enrollment within 60 days after such an event. 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.

Employee Name
Social Security #

Group #
Section # (required)



1. ACTION REQUESTED

<input type="checkbox"/> New Policy Application or <input type="checkbox"/> COBRA/Continuation Requested Effective Date: _____ (Optional) Network: _____ Select Coverage: (Check all that apply) <input type="checkbox"/> Health Product Name: _____ <input type="checkbox"/> Drug Product Name: _____ <input type="checkbox"/> Dental Product Name: _____ <input type="checkbox"/> Vision Product Name: _____ <input type="checkbox"/> Life Complete Life and Disability Benefit section	<input type="checkbox"/> Policy Change Requested Date of Change: _____ (Optional) Action: (Check the type of change) <input type="checkbox"/> Address change (Enter new address in Section 2) <input type="checkbox"/> Add dependent to policy (List dependent(s) in Section 3) <input type="checkbox"/> Delete dependent from policy (List dependent(s) in Section 3) <input type="checkbox"/> Add spouse due to marriage. Date Married: _____ (List spouse in Section 3) <input type="checkbox"/> Name change. Former Name: _____ <input type="checkbox"/> Cancel coverage <input type="checkbox"/> Other
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2. EMPLOYEE INFORMATION

Last Name	First Name	MI	Social Security#	Date of Birth (MM/DD/YYYY)	Gender <input type="checkbox"/> M <input type="checkbox"/> F
Employment Status <input type="checkbox"/> Active, Full Time Date of (Re)Hire: _____ <input type="checkbox"/> Retired <input type="checkbox"/> COBRA, Expiration Date: _____		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married, Date Married: _____ <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed			
Home Address		City	State	Zip Code	
Email Address			Home Phone Number		

3. COVERED DEPENDENTS

Relationship	First Name	Last Name (if different)	Social Security #	Date of Birth	Gender
Spouse					<input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/> Child ¹ <input type="checkbox"/> Adopted ² <input type="checkbox"/> Stepchild ¹ <input type="checkbox"/> Other ²					<input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/> Child ¹ <input type="checkbox"/> Adopted ² <input type="checkbox"/> Stepchild ¹ <input type="checkbox"/> Other ²					<input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/> Child ¹ <input type="checkbox"/> Adopted ² <input type="checkbox"/> Stepchild ¹ <input type="checkbox"/> Other ²					<input type="checkbox"/> M <input type="checkbox"/> 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
				<input type="checkbox"/> Age <input type="checkbox"/> End Stage Renal <input type="checkbox"/> Disability, Indicate Reason: _____
				<input type="checkbox"/> Age <input type="checkbox"/> End Stage Renal <input type="checkbox"/> Disability, Indicate Reason: _____

Important Notice for Medicare Eligible Individuals: If you are entitled to Medicare and Medicare is your primary coverage, you should enroll in and maintain that coverage, because when Medical Mutual is the secondary payer to Medicare Part B, Medical Mutual's plan will coordinate benefits as if you were covered under Part B, even if you are not. This can result in you being responsible for costs that would have been paid by Medicare. Your broker can assist you with any questions.
(If you are entitled to Medicare because you are over age 65 and your employer employs fewer than 20 employees; or if you are entitled to Medicare due to disability and your employer employs fewer than 100 employees, Medicare will be the primary payer, that is, Medicare must pay benefits before the group health plan pays benefits.)

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
				<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Hospital Only <input type="checkbox"/> Vision <input type="checkbox"/> Prescription Drug	<input type="checkbox"/> Active <input type="checkbox"/> Retired	<input type="checkbox"/> Single <input type="checkbox"/> 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: _____

Employee Name
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5. MEDICAL HEALTH QUESTIONNAIRE

Name	Height	Weight	Smoker	Name	Height	Weight	Smoker
Self:			<input type="checkbox"/> Y <input type="checkbox"/> N	Dependent:			<input type="checkbox"/> Y <input type="checkbox"/> N
Spouse:			<input type="checkbox"/> Y <input type="checkbox"/> N	Dependent:			<input type="checkbox"/> Y <input type="checkbox"/> N
Dependent:			<input type="checkbox"/> Y <input type="checkbox"/> N	Dependent:			<input type="checkbox"/> Y <input type="checkbox"/> N

A. MEDICAL CONDITIONS

Have you or any listed dependent in the past 5 years 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 1. <input type="checkbox"/> <input type="checkbox"/> AIDS/AIDS-Related Complex/HIV 2. <input type="checkbox"/> <input type="checkbox"/> Alcohol/Drug Dependency 3. <input type="checkbox"/> <input type="checkbox"/> Auto-Immune Disorder 4. <input type="checkbox"/> <input type="checkbox"/> Blood/Clotting Disorder 5. <input type="checkbox"/> <input type="checkbox"/> Cancer	Y N 6. <input type="checkbox"/> <input type="checkbox"/> Circulatory Disorder 7. <input type="checkbox"/> <input type="checkbox"/> Diabetes/Endocrine BS rdgs/HGB/A1C 1 _____ 2 _____ 3 _____ 8. <input type="checkbox"/> <input type="checkbox"/> Digestive/Intestinal Disorder 9. <input type="checkbox"/> <input type="checkbox"/> Heart Disease (including Hypertension)	Y N 10. <input type="checkbox"/> <input type="checkbox"/> Infertility 11. <input type="checkbox"/> <input type="checkbox"/> Kidney Disease 12. <input type="checkbox"/> <input type="checkbox"/> Liver Disease 13. <input type="checkbox"/> <input type="checkbox"/> Lung Disease 14. <input type="checkbox"/> <input type="checkbox"/> Mental Health Disorder 15. <input type="checkbox"/> <input type="checkbox"/> Muscle/Skeletal Disorder	Y N 16. <input type="checkbox"/> <input type="checkbox"/> Nervous System Disorder 17. <input type="checkbox"/> <input type="checkbox"/> Spinal/Disc Disorder 18. <input type="checkbox"/> <input type="checkbox"/> Stroke/TIA 19. <input type="checkbox"/> <input type="checkbox"/> Transplant 20. <input type="checkbox"/> <input type="checkbox"/> Tumor/Cyst 21. <input type="checkbox"/> <input type="checkbox"/> Other _____
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B. MEDICAL QUESTIONS

- Y N
- In the past 5 years, have you or any dependent been hospitalized or had surgery? (Explain in 5c)
 - In the past 5 years, have you or any dependent been advised to have an operation and/or further treatment which has not yet been performed? (Explain in 5c)
 - Are you or any dependent currently taking any prescription or over the counter medications? (Explain in 5c)
 - Are you or any dependent currently pregnant or expectant parent?
 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	<input checked="" type="checkbox"/> <input type="checkbox"/>
				<input type="checkbox"/> <input type="checkbox"/>
				<input type="checkbox"/> <input type="checkbox"/>
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				<input type="checkbox"/> <input type="checkbox"/>

Attach a separate sheet if additional space is required.

Employee Name
Social Security #

Group #
Section # (required)



6. 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
<input type="checkbox"/>	<input type="checkbox"/>	Basic Life		
<input type="checkbox"/>	<input type="checkbox"/>	Basic AD&D		
<input type="checkbox"/>	<input type="checkbox"/>	Dependent Life		
<input type="checkbox"/>	<input type="checkbox"/>	Short Term Disability		
<input type="checkbox"/>	<input type="checkbox"/>	Long Term Disability		
<input type="checkbox"/>	<input type="checkbox"/>	Supplemental Life		
<input type="checkbox"/>	<input type="checkbox"/>	Supplemental AD&D		

B. CLASS AND SALARY INFORMATION

Class:	Earnings: <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> 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:				

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.

Employee Name
Social Security #

Group #
Section # (required)



MEDICAL MUTUAL OF OHIO®

8. TERMS AND CONDITIONS

I hereby apply under Medical Mutual of Ohio® (MMO) for the health insurance coverage indicated on this application and to Consumers Life Insurance Company (CLIC) for life and/or disability income insurance coverage indicated on this Application.

I authorize: (1) payroll deduction(s) and remittance of any required contribution for coverage to MMO/CLIC and/or any affiliates or divisions of MMO/CLIC; (2) release of information, without limitation, from any medical/medically related facility, prior health insurance carrier, the Medical Information Bureau, Inc. (MIB), prescription history database supplier, government agency or person to MMO/CLIC and/or any affiliates or division of MMO/CLIC: (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 MMO/CLIC 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 MMO/CLIC 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 MMO/CLIC; (d) to bind MMO/CLIC 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 MMO/CLIC to be binding on MMO/CLIC.

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 MMO/CLIC 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 understand that I have a continuing obligation to report changes in my health status or the health status of any dependent listed on this application after I sign this application and before I receive written notice of approval. Changes in health status include, but are not limited to, being treated for or diagnosed as having a medical condition not listed on this application, or having been recommended for future surgery, diagnostic testing or medical treatment.

I agree that: (a) any untrue or incomplete information, statements 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 MMO/CLIC; (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 coverage will not begin until 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 MMO/CLIC to any person or organization except to reinsuring companies, the MIB, or other persons or organizations performing health care operation 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 on-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 MMO/CLIC'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 MMO/CLIC'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 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. Signature of spouse authorizes release of information described in this Application.

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.

Employee Application & Change Form

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Visit MedMutual.com.