



MEDICAL MUTUAL OF OHIO

EMPLOYER GROUP ENROLLMENT APPLICATION/CHANGE FORM MMO 2-99 ELIGIBLE EMPLOYEES

initial enrollment change

1. Group/Company Information

Business Name					
Has this business ever been known by another name? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what name(s)?					MMO Membership # (if applicable)
Business Address (No P.O. Boxes)			Billing Address		
City	County	State	Zip Code	Business Phone Number	
Chief Executive Officer		Billing Contact		Business Fax Number	
Business E-Mail			Number of years in business (If less than one year specify the date the business started.)		
Type of Business (be specific)		SIC Code		Employer/Federal Tax ID #	
Do you have any affiliations with other companies or unions (include parent, subsidiary, joint venture, etc...)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe.					Dun and Bradstreet #
If yes, do any of these affiliates qualify as a single employer under subsection (b), (c), (m), or (o) of the Internal Revenue Code Section 414? If yes, please give the legal names, federal tax ID# and number of employees.					Has group ever applied with MMO and/or CLIC? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, when?
					Is the employer contribution at least 25% of each contract? <input type="checkbox"/> Yes <input type="checkbox"/> No

2. Enrollment Criteria

Eligible Employee: State minimum # of hours to be worked per week for employees to be considered eligible for insurance benefits.
(Minimum must be 30 hours or more per week.) _____

Waive probationary period for initial enrollment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Probation Period for New Hire Benefits <input type="checkbox"/> Date of Hire <input type="checkbox"/> 30 days following Date of Hire <input type="checkbox"/> 60 days following Date of Hire <input type="checkbox"/> 90 days following Date of Hire <input type="checkbox"/> 180 days following Date of Hire	<input type="checkbox"/> First of month following Date of Hire <input type="checkbox"/> First of month following 30 days <input type="checkbox"/> First of month following 60 days <input type="checkbox"/> First of month following 90 days	Probation Period for Rehires <input type="checkbox"/> Same as Probationary Period for New Hires <input type="checkbox"/> Other _____
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Participation	Active**	COBRA	Retired**
Total number of current employees (part time & full time)			
Total number of eligible employees			
Number of eligible employees applying for coverage			

**Including owners, officers and partners who receive compensation from the company, reported on a tax other than a 1099.

Multiple Facilities: Do you have facilities in multiple locations? (Only applicable if applying for coverage) Yes No If yes, list where and employee counts.

City and State	Total Number of Employees	Total Number of Applicants

3. Health and Prescription Plans

Group Size	SuperMed Plus:	<input type="checkbox"/> P2080-250	<input type="checkbox"/> P2090-250	<input type="checkbox"/> P2580-250	<input type="checkbox"/> P3080-1000	<input type="checkbox"/> P3570-1000	Proposed Effective Date
2+		<input type="checkbox"/> P2080-500	<input type="checkbox"/> P2090-500	<input type="checkbox"/> P2580-500	<input type="checkbox"/> P3080-1500	<input type="checkbox"/> P3570-1500	
		<input type="checkbox"/> P2080-1000	<input type="checkbox"/> P2090-1000	<input type="checkbox"/> P2580-1000	<input type="checkbox"/> P3080-2000	<input type="checkbox"/> P3570-2000	
		<input type="checkbox"/> P2080-1500	<input type="checkbox"/> P2090-1500	<input type="checkbox"/> P2580-1500	<input type="checkbox"/> P3080-2500	<input type="checkbox"/> P3570-2500	
		<input type="checkbox"/> P2080-2500		<input type="checkbox"/> P2580-2500	<input type="checkbox"/> P3080-5000	<input type="checkbox"/> P3570-5000	
	Vital Access:	<input type="checkbox"/> P25100-3500	<input type="checkbox"/> P25100-7500		<input type="checkbox"/> P2580-3500	<input type="checkbox"/> P2580-7500	
		<input type="checkbox"/> P25100-5000	<input type="checkbox"/> P25100-10000		<input type="checkbox"/> P2580-5000	<input type="checkbox"/> P2580-10000	
	Prescription Drug Options:	<input type="checkbox"/> Option 1	<input type="checkbox"/> Option 2	<input type="checkbox"/> Option P4			
	HDHP: (HSA Compatible Plan)	<input type="checkbox"/> SMP P2500 Embedded	<input type="checkbox"/> SMP P3000 Embedded	<input type="checkbox"/> SMP P4000 Embedded	<input type="checkbox"/> SMP P5000 Embedded		
		<input type="checkbox"/> SMP P2500 Aggregate	<input type="checkbox"/> SMP P3000 Aggregate	<input type="checkbox"/> SMP P4000 Aggregate	<input type="checkbox"/> SMP P5000 Aggregate		
		<input type="checkbox"/> SMP P2500 Value Embedded	<input type="checkbox"/> SMP P2500 Value Aggregate	<input type="checkbox"/> SMP P1750 Value Aggregate			
51+		<input type="checkbox"/> Other (NBR Required) _____					
2+		<input type="checkbox"/> Medicare Carveout					

4. Dental and Vision Plans

2+/10+	Dental Without Orthodontia	<input type="checkbox"/> SuperDental 180	<input type="checkbox"/> SuperDental 186
25+	Dental With Orthodontia	<input type="checkbox"/> SuperDental 180	<input type="checkbox"/> SuperDental 186
2+		<input type="checkbox"/> SuperMed Vision Plan E	



5. Current and Prior Carrier History

A. List all carriers used for all product lines of insurance offered to the employees for the past 5 years. If there are no carriers, indicate NONE. (list current carrier first)

Carrier Name	Continuing Coverage Yes <input type="checkbox"/> No <input type="checkbox"/>	Benefits*	Dates		Current Rates**				Renewal Rates**			
			From	To	Employee	& Spouse	& Child	Family	Employee	& Spouse	& Child	Family
	Yes <input type="checkbox"/> No <input type="checkbox"/>											
	Yes <input type="checkbox"/> No <input type="checkbox"/>											
	Yes <input type="checkbox"/> No <input type="checkbox"/>											

*Examples: Traditional, Comprehensive Major Medical, Self Insured, etc... **If you're age banded with current carrier, please provide most recent billing statement.

B. Is any part of the employee's or dependent's deductible being funded by the employer or from an employer-established account?
 Yes No If yes, how much? Single: _____ Family: _____
 Does the employer fund first? Yes No

6. Validations

Groups completing the Employer Risk Assessment Form may skip Sections A & B.

A. Has anyone within the past 24 months missed work due to any disability or work related injury?
 Yes No If yes, provide details below.

Employee Name	Provide details (i.e. description of condition) based upon your work records

B. Is anyone currently COBRA eligible/enrolled?
 Yes No If yes, provide details below.

Name	Social Security #	Beginning Date	Expiration Date	Qualifying Event

C. Are there any retirees who meet the eligibility requirements AND are members of a formal retirement program?
 Yes No If yes, provide details below.

Name	Social Security #	Age at Retirement	Date of Retirement	Date of Hire	Avg. Hrs. Worked Per Week Prior to Retirement



7. Life and Disability Plans

Life, AD&D, Dependent Life and Short-Term Disability

If the Company approves this application, a policy will be issued. The applicant agrees that acceptance of the Policy will be approval of the policy terms.

Proposal number _____ is incorporated by reference in and made part of this application for all purposes.

If multiple plans are indicated on the proposal, indicated plan number elected _____

If participation-free, voluntary coverages are being elected, please indicate below:

Yes, I am electing participation-free Voluntary Life and AD&D

Yes, I am electing participation-free Voluntary Life and AD&D, and short-term disability

If participation-free, voluntary short-term disability is elected, indicate the plans: 1/8/13 1/8/26

Waiting period is identical to medical probationary period, unless indicated below:

- None
- First of month following completion of _____ days
- Other _____

Employees working less than **20 hours** per week are not eligible for coverage. If different than 20 hours, please indicate number of hours: _____

Employer contribution percentages (%) for all products are as stated in the proposal, unless indicated below:

Group Long-Term Disability

If the Company approves this application, a policy will be issued. The applicant agrees that acceptance of the policy will be approval of the policy terms.

Proposal number _____ is incorporated by reference in and made part of this application for all purposes.

Prior Carrier: _____
(Prior carrier must be listed and a copy of the prior policy included for **continuity of coverage** to apply.)

Termination Date of prior policy: _____

Waiting period – present employees: _____

Waiting period – future employees: _____

Employees working less than **30 hours** per week are not eligible for coverage. If different than 30 hours, please indicate number of hours: _____

Contribution:

Employer _____% Employee _____% Pre-tax dollars Post-tax dollars



8. Terms and Conditions

1. The group named herein, which is duly organized under the laws of Indiana, hereby applies to Medical Mutual of Ohio® (MMO) for the benefits selected herein. The group understands and acknowledges that the actual benefits will be specified in the group contract if this application is accepted by MMO, and that benefits will take effect as of the date specified in such group contract. **This Employer/Group Enrollment Application is not a contract for healthcare benefits. Continue your current coverage until you are notified in writing that MMO has accepted this application.**
2. For all groups: Each employee not enrolling must complete the Waiver on the cover page of the Employee Application and Change Form and Medical History Questionnaire. For groups with 2 - 50 members: Each employee enrolling must complete all sections of the Employee Application and Change Form and Medical History Questionnaire (Sections 1 - 8).
3. To be eligible for coverage, an individual must be a full time employee of the group or company applying for coverage. Any individual who applies for insurance coverage from MMO must be a full-time common law employee, drawing a regular paycheck and with compensation reported on IRS Form W-2. Independent contractors of the group or company are not eligible for coverage.
4. To be eligible for coverage by MMO, the group or company must be in compliance with all applicable state and federal laws.
5. Any untrue or incomplete information, statements or answers on this application (whether intentional or not) or engaging in any fraudulent conduct, deception or misrepresentation relating to any application, coverage, claim or usage of a MMO identification card can result in denial of a claim or rescission of coverage for the group or any group member, and may subject the group or any group member to legal action by MMO.
6. Approval and acceptance of this Employer/Group Enrollment Application and individual Employee Applications are subject to MMO underwriting guidelines.
7. It is agreed that this Employer/Group Enrollment Application supersedes any previous applications for this group coverage.
8. By signing this Employer/Group Enrollment Application, the authorized representative of the group or company represents that the group or company is not an entity that has been formed primarily to obtain health insurance coverage, and it does not permit membership in the group or company solely for the purpose of obtaining health insurance coverage.
9. The group hereby authorizes MMO to obtain information from prior carriers to determine existence of pre-existing conditions. Prior carriers are authorized to release such information to MMO upon receipt of a copy of this application.
10. I understand and agree that no agent or broker has the authority: (a) to bind MMO by making promises regarding eligibility, benefits, or the issuance of a policy; (b) to waive any answer or any portion of any answer to any question on this application or any information MMO requests; (c) approve coverage; (d) make or alter any contract on behalf of MMO; or (e) waive or alter any of MMO other rights or requirements. All contract terms must be in writing and signed or accepted in writing by an authorized representative of MMO to be binding on MMO.
11. The group or company hereby appoints the Secretary of Medical Mutual of Ohio as its proxy, with power of substitution, to act for and on its behalf at any and every annual meeting or any special meeting of the members of Medical Mutual of Ohio. The group or company authorizes its proxy to vote and act for and on behalf of the member at such meeting as fully and to the same extent as the member could do present thereat. This proxy shall continue in force until ten years from the date hereof unless sooner revoked by a notice in writing signed by the group and delivered to Medical Mutual of Ohio.

9. Authorized Signature (Please print)

Business Name	Name (print)	Title
Authorized Signature		Date
Broker Signature (if applicable)	Broker Name (print) (if applicable)	
Federal Tax ID	Royal Advantage Broker	

WARNING: Any person who, with intent to defraud or knowing that he 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.