CONSUMERS LIFE INSURANCE COMPANY®
A MEDICAL MUTUAL OF OHIO® Company | health plans for life

EMPLOYEE
APPLICATION and CHANGE FORM
for individuals in
Groups 51+ 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.: DROPPING DEPENDENTS, ADDRESS CHANGES...**
- **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.**

WAIVER

A. Waived Coverages: I do NOT want...(Check one)

☐ HEALTH through Consumers Life Insurance Company, a Medical Mutual of Ohio Company
☐ HEALTH through Consumers Life for the following dependents only: (Remember to complete the rest of this application)

1)____________ 2)____________ 3)____________ 4)____________ 5)____________

B. Current Health Coverage Status: I have...(Check one)

☐ Coverage through my Spouse's Employer: ______________________
Spouse's Company Name
☐ No coverage
☐ Other coverage: ______________________

C. Authorization: The terms of this waiver are explained below. I have read and understand these terms.

Company Name: ______________________

Print Employee Name: ______________________ Employee Social Security #: ______________________

Print Spouse Name: ______________________ Spouse Social Security #: ______________________

Signature of Employee: ______________________ Date: ______________________

THE EXPLANATION OF WAIVER

I understand that if I check any box in Question A of the Waiver above that 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 health 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 may 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.

HEALTH APPLICATION / CHANGE

GROUP # | SECTION

1. (Please Print) ABOUT YOU AND YOUR JOB...

LAST NAME
SOCIAL SECURITY NUMBER
FIRST NAME | M.I. | DATE OF BIRTH / / | SEX (M or F)
STREET ADDRESS
CITY | STATE | ZIP CODE
HOME PHONE NUMBER ( ) -
MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED
EMAIL ADDRESS

COMPANY NAME/EMPLOYER
OCCUPATION/JOB TITLE | EMPLOYEE/CLOCK #
DEPARTMENT NAME | DEPT. #
FULL TIME DATE OF (RE)HIRE / /
EMPLOYMENT STATUS ☐ ACTIVE ☐ RETIRED ☐ COBRA
BUSINESS PHONE ( ) - EXT.
COBRA EXPIRATION DATE / /
EMAIL ADDRESS

2. (Please Print) WHAT YOU WANT DONE...

A) NEW POLICY APPLICATION

1. Type of Coverage:
   PRIMARY COVERAGE
   MEDICAL
   Product Name ______________________________
   ADDITIONAL COVERAGE(S): (check all that apply)
   ☐ Vision ☐ Dental
2. Who Do You Want Covered?
   ☐ You Only ☐ You and One Other Person ☐ You and Your Family

B) CHANGE TO AN EXISTING POLICY

1. Group # ____________ Section # ____________
2. Date of Change: ____/____/____
3. Action (Check the Type of Change)
   - ☐ ADD DEPENDENT TO POLICY (LIST DEPENDENTS IN SECTION 3 BELOW)
   - ☐ DELETE DEPENDENT FROM POLICY (LIST DELETED DEPENDENTS IN SECTION 3 BELOW)
   - ☐ MARRIAGE: DATE MARRIED: ____________________
   - ☐ NAME CHANGE: FORMER NAME: ________________________________
   - ☐ OTHER: ____

3. (Please Print) ABOUT YOU AND YOUR DEPENDENTS...

A.	(A)dd (C)hange (D)elete	First Name	Last Name	Social Security #	Date of Birth	Sex M or F	Height	Weight	Relationship to you**
Self				- -	- -				
Spouse				- -	- -				
1				- -	- -				
2				- -	- -				
3				- -	- -				
4				- -	- -				
5				- -	- -				

**Relationship to You: C = child, SC = stepchild, AC = adopted child*, O = other* (*attach legal documentation)

4. (Please Print) ABOUT YOUR OTHER HEALTH INSURANCE AND MEDICARE...

What date did your most recent health insurance or health benefit program become effective (check box if no prior/current coverage)? / / ☐ No Coverage

What date did/will the above health insurance or health benefit program terminate? / /

DO YOU OR ANY OF YOUR DEPENDENTS HAVE ANY OTHER HEALTH OR DENTAL COVERAGE? ☐ **YES** ☐ **NO** **IF YES, COMPLETE THE SECTION BELOW.**

NAME OF POLICY HOLDER	NAME AND ADDRESS OF OTHER INSURANCE COMPANY	POLICY NUMBER	EFFECTIVE DATE	COVERAGE TYPES	WORK STATUS	POLICY TYPE
			/ /	☐ Medical ☐ Dental ☐ Hospital Only ☐ Vision ☐ Prescription Drug	☐ Active ☐ Retired	☐ Single ☐ Family
			/ /	☐ Medical ☐ Dental ☐ Hospital Only ☐ Vision ☐ Prescription Drug	☐ Active ☐ Retired	☐ Single ☐ Family

MEDICARE INFORMATION:

Are you covered by Medicare? ☐ YES ☐ NO If YES, Medicare No. ________________
EFFECTIVE DATE: PART A: / / PART B: / /
☐ Hemodialysis

Is your spouse or dependent covered by Medicare? ☐ YES ☐ NO If YES, Medicare No. ________________
EFFECTIVE DATE: PART A: / / PART B: / /
☐ Hemodialysis

6. THE TERMS AND WHAT YOU DECLARE

I hereby apply to Consumers Life Insurance Company for the coverage indicated on this application.

* I authorize: (1) payroll deduction(s) and remittance of any required contribution for coverage to Consumers Life and or any administrator designated by Consumers Life ; (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 recision of coverage and may subject me to legal action by Consumers Life; (2) to be eligible for health coverage, I must be an active full-time employee, as defined by my employer; (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 Consumers Life 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 Consumers Life requests; (3) approve coverage; (4) make or alter any contract on behalf of Consumers Life; or (5) waive or alter any of Consumers Life Insurance Company's other rights or requirements. All contract terms must be in writing and signed or accepted in writing by an autho rized representative of Consumers Life to be binding on Consumers Life.

7. SIGNATURES - Sign after completing and reading all applicable sections (including front of this application).

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 on the front of this application.

Your Signature	Date	Your Spouse's Signature (if applying for dependent coverage)	Date

WARNINGS: Any person who, with 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.

If you or your family members are covered by more than one health care 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.