



EMPLOYEE APPLICATION and CHANGE FORM

for individuals in
Groups up to 9 Eligible



INSTRUCTIONS

- ALWAYS PRINT CLEARLY USING A BLUE OR BLACK PEN (NO HIGHLIGHTERS)
- ALWAYS PUT SUBSCRIBER ID NUMBER AND GROUP NUMBER ON APPLICATION.
- NEW HIRES, LATE ENTRANTS, AND DEPENDENT ADDITIONS MUST COMPLETE THE APPLICATION AND MEDICAL HISTORY QUESTIONNAIRE.
- OTHER CHANGES COMPLETE ONLY AREA THAT IS CHANGING E.G: DROPPING DEPENDENTS, ADDRESS CHANGE, PHYSICIAN CHANGE, PRODUCT CHANGE...
- IF WAIVING COVERAGE COMPLETE WAIVER AREA.

(Please Print)

ABOUT YOUR NEEDS

If you have a special language or other cultural need that may affect the administration of your health plan or health care delivery, please indicate below so that Medical Mutual of Ohio could better assist you:

- _____ Hearing-impaired (require use of TDD/TTY 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 _____

• If you do not want any coverage OR if you reject some of the coverage options but accept others, complete this waiver...

WAIVER

Check One Box in Section A and Complete Sections B and C.

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

- HEALTH and LIFE/DISABILITY through Medical Mutual of Ohio (MMO) and MLI
- HEALTH through MMO
- LIFE/DISABILITY through MLI
- Health through MMO 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 Current Employer: Other Insurance Company Name: _____
- Coverage through my Spouse's Employer: _____
- Spouse's Company Name Spouse's Name Spouse's SS#
- Other coverage through MMO No coverage Other coverage: _____

C. Authorization: The terms of this waiver are explained in Section 8 of this application. I have read and understand those terms.

Current Employer/Company Name: _____

Print Employee Name: _____ Employee Social Security #: _____

Print Spouse Name: _____ Spouse Social Security #: _____

Signature of Employee: _____ 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. (Ohio Revised Code Section 3999.21)

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. (Ohio Admin. Code Section 3901-1-56)

Application Reminders



DID YOU FILL IN ALL THE FIELDS IN SECTION 1? →

IF YOUR EMPLOYER IS OFFERING A CHOICE OF HEALTH COVERAGES, PLEASE COMPLETE THE SECTION AT THE BOTTOM OF PAGE 4. →

← **REMEMBER PAGE 1** WAIVER MUST BE COMPLETED IF NOT TAKING HEALTH OR NOT COVERING ONE OF YOUR DEPENDENTS. ALSO PLEASE PUT SOCIAL SECURITY NUMBER OF SPOUSE IF SPOUSE IS WAIVING COVERAGE.



DID YOU PUT THE START & END DATE OF PRIOR COVERAGE? →



DON'T FORGET TO SIGN AND DATE.....SPOUSE TO SIGN IF MARRIED →

Application Reminders



DON'T FORGET HEIGHT AND WEIGHT!!



IF YOU CHECKED ***YES*** FOR ANY CONDITION

THEN

COMPLETE

SECTION 7C



MAKE SURE TO WRITE AN ***EXPLANATION*** HERE!



MEDICAL HISTORY QUESTIONNAIRE (for groups with up to 9 eligible employees)

7. Applicant		Social Security Number	Group Number	Date of Birth	Height	Weight	
Last							
Dependents (Full Name)	Date of Birth	Height	Weight	Dependents (Full Name)	Date of Birth	Height	Weight
Spouse							
1			4				
2			5				
3			6				

7A. Check all medical conditions, diseases listed below for which you or any of your dependents have, or have ever been diagnosed, treated or counselled: (Use number and letter to identify conditions in 7C)

<input type="checkbox"/> 1. Transplant (any organ)	<input type="checkbox"/> 19. Other Lung Disorders	<input type="checkbox"/> 36. Coronary Artery Disease
<input type="checkbox"/> 2. Connective Tissue Disease	<input type="checkbox"/> 20. Liver Disorders	<input type="checkbox"/> 37. Bypass Surgery
<input type="checkbox"/> 3. A.I.D.S./A.R.C./H.I.V.	<input type="checkbox"/> 21. Congenital Disease/Defect	<input type="checkbox"/> 38. Congestive Heart Failure
<input type="checkbox"/> 4. Arthritis, Osteo	<input type="checkbox"/> 22. Paralysis	<input type="checkbox"/> 39. Pacemaker
<input type="checkbox"/> 5. Arthritis, Rheumatoid	<input type="checkbox"/> 23. Multiple Sclerosis	<input type="checkbox"/> 40. Ischemic Heart Disease
<input type="checkbox"/> 6. Back/Spinal Disorder	<input type="checkbox"/> 24. Cerebral Palsy	<input type="checkbox"/> 41. Other Heart Disorders
<input type="checkbox"/> 7. Scoliosis	<input type="checkbox"/> 25. Epilepsy	<input type="checkbox"/> 42. High Blood Pressure
<input type="checkbox"/> 8. Spina Bifida	<input type="checkbox"/> 26. Parkinson's	<input type="checkbox"/> 43. Yes, Give Last 3 Blood Pressures & Dates A. B. C.
<input type="checkbox"/> 9. Ulcerative Colitis	<input type="checkbox"/> 27. Alzheimer's Disease	
<input type="checkbox"/> 10. Diverticulitis	<input type="checkbox"/> 28. Other Neurological Disorders	<input type="checkbox"/> 44. Alcohol or Drug Dependency
<input type="checkbox"/> 11. Crohn's Disease	<input type="checkbox"/> 29. Hemophilia	<input type="checkbox"/> 45. Attempted Suicide
<input type="checkbox"/> 12. Gastric/Peptic Ulcer	<input type="checkbox"/> 30. Kidney/Urinary Disorders	<input type="checkbox"/> 46. Anorexia/Bulimia
<input type="checkbox"/> 13. Other Bowel/Stomach Disorders	<input type="checkbox"/> 31. Tumors/Growths	<input type="checkbox"/> 47. Chronic Depression
<input type="checkbox"/> 14. Stroke (Date)	<input type="checkbox"/> 32. Juvenile Diabetes	<input type="checkbox"/> 48. Other Mental/Emotional Disorders
<input type="checkbox"/> 15. Cancer, Leukemia or Melanoma	<input type="checkbox"/> 33. Diabetes Mellitus	<input type="checkbox"/> 49. Venereal Disease
<input type="checkbox"/> 16. Emphysema	<input type="checkbox"/> 34. Yes, Give Last 3 Blood Sugars & Dates A. B. C.	<input type="checkbox"/> 50. Deafness
<input type="checkbox"/> 17. Chronic Bronchitis		<input type="checkbox"/> 51. Currently Pregnant
<input type="checkbox"/> 18. Asthma	<input type="checkbox"/> 35. Heart Attack/M.I.	If so, state expected date / / /

7B. MEDICAL QUESTIONS

1) Within the past 5 years, have you or your dependents had, or been treated for, or been told that you have any other condition/disorder/disease not listed above? If yes, explain in 7C.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2) Within the past 5 years, have you or your dependents been hospitalized, operated on or been advised to have an operation which has not yet been performed? If yes, explain in 7C.	<input type="checkbox"/>	<input type="checkbox"/>
3) Have you or any DEPENDENT listed been treated on an outpatient basis: Testing, Rehabilitation, Home Health Care or Emergency Room within the last two years? If yes, explain in 7C.	<input type="checkbox"/>	<input type="checkbox"/>
4) Within the past 5 years, have you or your dependents been on Fertility Drugs, had a High Risk Pregnancy, Abnormal Pap Test, or a Venereal Disease? If yes, explain in 7C.	<input type="checkbox"/>	<input type="checkbox"/>
5) Are you or any of your dependents currently taking any prescription medications? If Yes, indicate medication, reason for taking and dosage per day in Section 7C.	<input type="checkbox"/>	<input type="checkbox"/>
6) Do any of the conditions identified above involve Worker's Compensation? If Yes, provide the Worker's Compensation Case Number: #: _____	<input type="checkbox"/>	<input type="checkbox"/>
7) Have you or your dependents ever been restricted from, or declined for coverage by any carrier? If yes, explain in 7C.	<input type="checkbox"/>	<input type="checkbox"/>

7C. EXPLANATION

Condition/ Question #	Individual (FULL NAME)	Physician's Name and Address	Treatment Dates (FROM /TO)	Diagnosis, Treatment, Prognosis, Medication, Dosage and Reason (be specific)

Attach a separate sheet in this format if more space is required.

BLANK

THE EXPLANATION OF WAIVER

I understand that if I check any box in Question A of the Waiver on the front cover of this application OR check "NO" under any coverages offered in Section 6, that 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 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 30 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.

THE TERMS AND WHAT YOU DECLARE

I hereby apply to Medical Mutual of Ohio (MMO) and/or to Medical Life Insurance Company (MLI) for the coverage indicated on this application.

- * I authorize: (1) payroll deduction(s) and remittance of any required contribution for coverage to MMO, MLI and/or any affiliates or divisions of MMO; (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 rescission of coverage and may subject me to legal action by MMO or MLI; (2) to be eligible for health coverage, I must be an active full-time employee, as defined by my employer; (3) I must be actively at work, as defined in the group's insurance policy to obtain life and/or disability coverage. If I am not actively at work on the date my life and/or disability coverage would become effective, my coverage will not begin until the day I return to work; (4) 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 MMO 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 MMO requests; (3) approve coverage; (4) make or alter any contract on behalf of MMO; or (5) waive or alter any of MMO's 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.

SUPERMED CHOICE OPTIONS

Description	Please Select PRODUCT and INITIAL THE BOX
Package 1	
SM Plus 15100	
SM Plus 1590	
SM Plus 1580	
SM Plus 1570	
SM Plus 2080-1000	
Package 2	
SM Plus 2080-250	
SM Plus 2080-500	
SM Plus 2080-750	
SM Plus 2000	
Package 3	
SM Plus 2070	
SM Plus 2000	
SM Plus 2060	
SM Plus 2560	