



EMPLOYEE APPLICATION and CHANGE FORM

**for individuals in
Groups 10+ 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 these 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)

HEALTH AND LIFE APPLICATION / POLICY CHANGE

GROUP # _____ SECTION _____

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

YOUR LAST NAME		YOUR SOCIAL SECURITY NUMBER		COMPANY NAME/EMPLOYER	
YOUR FIRST NAME	M.I.	YOUR DATE OF BIRTH / /	SEX (M or F)	OCCUPATION/JOB TITLE	EMPLOYEE/CLOCK #
YOUR STREET ADDRESS			E MAIL ADDRESS		DEPARTMENT NAME
					PAYROLL LOCATION/DEPT. #
CITY		STATE	ZIP CODE	FULL TIME DATE OF (RE)HIRE / /	
				EMPLOYMENT STATUS <input type="checkbox"/> ACTIVE <input type="checkbox"/> RETIRED <input type="checkbox"/> COBRA	
HOME PHONE NUMBER () -	MARITAL STATUS: <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED		DATE MARRIED / /	BUSINESS PHONE () - EXT. / /	
				COBRA EXPIRATION DATE / /	

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

<p>A) NEW POLICY APPLICATION</p> <p>1. Type of Coverage: PRIMARY COVERAGE: (check only one) <input type="checkbox"/> SuperMed Classic <input type="checkbox"/> SuperMed Share <input type="checkbox"/> SuperMed Plus <input type="checkbox"/> SuperMed Choice Options (refer to key at bottom of page 4)</p> <p>ADDITIONAL COVERAGE(S): (check all that apply) <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life only</p> <p>2. Who Do You Want Covered? <input type="checkbox"/> You Only <input type="checkbox"/> You and One Other Person <input type="checkbox"/> You and Your Family Medicare Supplement For: <input type="checkbox"/> You <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent</p>	<p>B) CHANGE TO AN EXISTING POLICY</p> <p>1. Date of Change: ___/___/___ 2. Requested Effective Date: ___/___/___</p> <p>3. Action (Check the Type of Change)</p> <p><input type="checkbox"/> ADD DEPENDENT TO POLICY (LIST DEPENDENTS IN SECTION 3 BELOW) <input type="checkbox"/> DELETE DEPENDENT FROM POLICY (LIST DELETED DEPENDENTS IN SECTION 3 BELOW) <input type="checkbox"/> BENEFIT CHANGE (INDICATE CHOICE TO THE IMMEDIATE LEFT UNDER SECTION A) <input type="checkbox"/> NAME CHANGE: FORMER NAME: _____ <input type="checkbox"/> TERMINATED EMPLOYMENT <input type="checkbox"/> DECEASED <input type="checkbox"/> REQUESTED CANCELLATION <input type="checkbox"/> OTHER: _____</p>
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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? / / Name of Prior Carrier _____

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 <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Hospital Only <input type="checkbox"/> Vision <input type="checkbox"/> Prescription Drug	WORK STATUS <input type="checkbox"/> Active <input type="checkbox"/> Retired	POLICY TYPE <input type="checkbox"/> Single <input type="checkbox"/> Family

MEDICARE INFORMATION:
 Are you covered by Medicare? YES NO If YES, Medicare No. _____
 Is your spouse or dependent covered by Medicare? YES NO If YES, Medicare No. _____

EFFECTIVE DATE: PART A: / / PART B: / / REASON FOR MEDICARE
 AGE DISABILITY END STAGE RENAL

5. (Please Print) ABOUT YOUR LIFE AND DISABILITY INSURANCE...

IF YOUR EMPLOYER OFFERS ANY OF THE FOLLOWING COVERAGES, PLEASE INDICATE IF YOU WOULD LIKE TO ENROLL IN ANY OF THESE COVERAGES AND THE AMOUNT.

BASIC LIFE <input type="checkbox"/> YES <input type="checkbox"/> NO	DEPENDENT LIFE <input type="checkbox"/> YES <input type="checkbox"/> NO	SUPPLEMENTAL LIFE <input type="checkbox"/> YES (AMT. \$ _____) <input type="checkbox"/> NO	SUPPLEMENTAL AD&D <input type="checkbox"/> YES (AMT. \$ _____) <input type="checkbox"/> NO	SHORT TERM DISABILITY <input type="checkbox"/> YES <input type="checkbox"/> NO	LONG TERM DISABILITY <input type="checkbox"/> YES <input type="checkbox"/> NO
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IF ANY YES BOX IS CHECKED ABOVE, COMPLETE THE REMAINDER OF THIS SECTION.

GROUP/DIVISION NUMBER: _____ CLASS: _____ SALARY \$ _____
 HOURLY WEEKLY MONTHLY ANNUAL

FOR MLI USE ONLY
EFFECTIVE DATE: / /

	Social Security Number	Beneficiary Last Name	Beneficiary First Name	Date of Birth	Relationship	Benefit Split**
PRIMARY						%
SECONDARY						%

** Unless otherwise noted, if two primary beneficiaries are named, the proceeds will be paid in equal shares to the primary beneficiaries surviving you.

6. 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



Medical Mutual of Ohio
MEDICAL HISTORY QUESTIONNAIRE
For groups with 10 or more eligible employees, late entrants for
groups 51 or more eligible employees

1. In the section below please provide the details of any medical condition for which you or your dependents have received treatment within the past five years. Conditions include, but are not limited to, AIDS or AIDS-Related Complex; alcohol or drug dependency, arthritis, cancer, diabetes, diseases of the heart, lung, kidney or blood, mental health disorder, muscle or nervous system disorder, spinal disc disease, transplant, autoimmune disorder, infertility or any other medical condition not listed.

Name of Individual	Condition, Illness or Injury	Dates of Treatment From/To	Treatment Details/Current Status*

2. In the section below please provide the details for any medical condition for which you, your spouse or any listed dependent have been treated, diagnosed as having, or thought you should seek medical advice that is not listed above.

Name of Individual	Condition, Illness or Injury	Dates of Treatment From/To	Treatment Details/Current Status*

3. Are you, your spouse, or any listed dependent(s) currently taking any prescriptions or over the counter medications? Yes No (circle one) If yes, please list all medications.

Name of Individual	Medication(s)	Frequency/Dosage	Condition Being Treated*

4. Are you, your spouse, or any dependent currently pregnant or an expectant parent? Yes No (circle one)
 If yes, please provide: Name: _____, Relationship _____, Due Date: _____

REQUIRED FOR ALL 51-99 ELIGIBLE EMPLOYEES

Have you or any of your dependents ever been treated for heart disease, cancer, diabetes, transplants, nervous system and muscle disorder, AIDS or AIDS related complexes, or mental disorders or any other serious medical conditions?

Yes No If YES, you must provide an explanation or complete questions 1-4 above.

8.**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.

9.**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; (5) for SuperMed Select applicants ONLY - maximum benefits are not provided for services, supplies or charges, unless they are provided, arranged and authorized by a Plan Physician and approved by a Plan Medical Director.
- * 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 REFERENCE

Package 1	Package 2	Package 3
SM Plus 15100	SM Plus 2080-250	SM Plus 2070
SM Plus 1590	SM Plus 2080-500	SM Plus 2000
SM Plus 1580	SM Plus 2080-750	SM Plus 2060
SM Plus 1570	SM Plus 2000	SM Plus 2560
SM Plus 2080-1000		