



Employee Application / Change Form (For 51+ Groups Only)

(PLEASE USE BALL POINT PEN)

New Enrollee Re-hire Coverage Change
 Date of Hire _____ Date _____ Date _____

GROUP NO.: _____ **SECTION NO.:** _____ **LEVEL OF BENEFITS:** Single Family Employee/Spouse
 Employee/Child(ren) Two Persons Medicare Supplemental **EMPLOYMENT STATUS:** Active Retired COBRA

EMPLOYEE CLOCK NUMBER: _____ **EMPLOYEE DEPT. NO.:** _____ **PAYROLL LOCATION:** _____

CHANGES: Add Dependents due to: New Name Other _____
 Marriage Birth Adoption New Address
 Drop Dependents Due To: Change to Medicare Elig. **DATE OF EVENT** MO. _____ DAY _____ YR. _____
 Divorce Death Other _____ Change Coverage **COV. OR CHANGE EFF. DATE** MO. _____ DAY _____ YR. _____

Last Name _____ First Name _____ M Initial _____ E-mail Address _____

Street Address _____ City _____ State _____ Zip _____ Phone No. _____

Employee Date of Birth MO. _____ DAY _____ YR. _____ Sex M F Employee Social Security Number _____ Marital Status: Single Married Widowed
 Divorced Legal Separation Date Married MO. _____ DAY _____ YR. _____

Employer or Group Name _____ Date of Hire-Full Time MO. _____ DAY _____ YR. _____ Job Title _____

Check Coverage Desired: Health: Benefit Option or Product Desired _____ Prescription Drug Dental Vision

For HMO and Point-of-service plans, complete the following:
 Primary Care Physician Name _____ State _____ Current Patient? YES NO

MEDICARE INFORMATION Are you covered by Medicare? YES NO If YES, Medicare No. _____ Effective Date: _____ Hemodialysis
 Is your spouse covered by Medicare? YES NO If YES, Medicare No. _____ Effective Date: _____ Hemodialysis

OTHER INSURANCE INFORMATION **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
			/ /	<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
			/ /	<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

What date did your most recent health insurance program become effective (check box if no prior/current coverage)? ____/____/____ No coverage
 What date did/will this health insurance program terminate (check box if no prior/current coverage)? ____/____/____

RELATIONSHIP	BIRTHDATE	SEX	LAST NAME (ONLY IF DIFFERENT)	FIRST NAME	SOC. SEC. NO.	OVER AGE DEPENDENT STATUS
Spouse	MO. _____ DAY _____ YR. _____	<input type="checkbox"/> M <input type="checkbox"/> F				
<input type="checkbox"/> Child <input type="checkbox"/> Adopted <input type="checkbox"/> Stepchild <input type="checkbox"/> Other ¹		<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> F/T Student <input type="checkbox"/> Lw/Ab Health <input type="checkbox"/> Disabled Medicare Elig.; <input type="checkbox"/> Hemodialysis <input type="checkbox"/> Disability
<input type="checkbox"/> Child <input type="checkbox"/> Adopted <input type="checkbox"/> Stepchild <input type="checkbox"/> Other ¹		<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> F/T Student <input type="checkbox"/> Lw/Ab Health <input type="checkbox"/> Disabled Medicare Elig.; <input type="checkbox"/> Hemodialysis <input type="checkbox"/> Disability
<input type="checkbox"/> Child <input type="checkbox"/> Adopted <input type="checkbox"/> Stepchild <input type="checkbox"/> Other ¹		<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> F/T Student <input type="checkbox"/> Lw/Ab Health <input type="checkbox"/> Disabled Medicare Elig.; <input type="checkbox"/> Hemodialysis <input type="checkbox"/> Disability
<input type="checkbox"/> Child <input type="checkbox"/> Adopted <input type="checkbox"/> Stepchild <input type="checkbox"/> Other ¹		<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> F/T Student <input type="checkbox"/> Lw/Ab Health <input type="checkbox"/> Disabled Medicare Elig.; <input type="checkbox"/> Hemodialysis <input type="checkbox"/> Disability

1. Legal Documentation (court decree, guardianship papers, etc.) must be attached to this application if relationship is marked other.

PRE-EXISTING CONDITION NOTICE
 The following is applicable if your group imposes a pre-existing condition exclusion: 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 have 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.

BASIC INFORMATION

DEPENDENT INFORMATION

PRE-EXISTING CONDITION NOTICE

TERMS AND CONDITIONS

I hereby apply for the coverage indicated on this Application.

I authorize: (1) payroll deduction(s) and remittance of any required contribution for my coverage to Medical Mutual, any affiliates or division of Medical Mutual, and/or the sponsor of my group health plan; (2) release of information, without limitation, from any medical/medically-related facility, prior health carrier, the Medical Information Bureau (MIB), government agency or person to Medical Mutual and/or any affiliates or division of Medical Mutual: (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 Medical Mutual and/or the sponsor of my group health plan 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.

My dependents and I understand and agree that any information obtained will not be released by Medical Mutual to any person or organization, except to reinsuring companies, the MIB, or other persons or organizations performing health care operations 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 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 one-half years. I have the right to revoke this authorization at any time. My revocation must be in writing. The revocation will not apply to information that has already been released in response to this authorization. The revocation may adversely affect my Application or a pending insurance action.

I understand and acknowledge that this authorization extends to all medical records, including records that 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.

If applying for either a health maintenance organization (HMO) or point of service (POS) plan, I understand that: (1) Enrollee access is restricted to network health care providers; (2) I am required to have a network physician provide or arrange for all medical services (except maternity or life-threatening emergencies) to receive any benefits, in the case of an HMO plan, or the highest level of benefits, in the case of a POS plan; and (3) I will receive a list of plan physicians and plan facilities upon enrollment and/or request.

SIGNATURE

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 or member of the group and that the information I have provided is true and complete to the best of my knowledge.

Employee Signature

Date

Note: 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. (Ohio Revised Code Section 3999.21)

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 Drug Dental Vision through Medical Mutual®
- Dependent: Health Drug Dental Vision through Medical Mutual for the following spouse and/or dependent(s) only:

1 _____ 2 _____ 3 _____ 4 _____ 5 _____

Please indicate reason for waiving coverage:

- No coverage
- Employee/dependent has existing coverage. Insurance company name: _____

B. 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 coverage 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 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 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 No.: _____

Print Spouse Name: _____ Spouse Social Security No.: _____

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.