COSE
COUNCIL OF SMALLER ENTERPRISES

MEDICAL MUTUAL®

Employee Application/Change Form
For Groups With Under 50 Eligible Employees

CONSUMERS LIFE®
A MEDICAL MUTUAL COMPANY

Section I: INSURANCE WAIVER

I understand that if I check any box in Part 1 of this waiver I am choosing not to have those persons covered under the health, life or disability insurance designated.

Part 1: Waived Coverages: I do not want coverage for (Check all that apply)

Myself:	☐ Medical	☐ Dental	☐ Vision	☐ Life/Disability
Spouse or Domestic Partner:	☐ Medical	☐ Dental	☐ Vision	☐ Life/Disability
Child(ren) over age 18:	☐ Medical	☐ Dental	☐ Vision	☐ Life/Disability
Child(ren) 18 and under:	☐ Medical	☐ Pediatric Dental*		☐ Life/Disability

Please list name(s) of spouse/domestic partner and/or child(ren) for whom coverage is being waived:

_____

* The Affordable Care Act requires that small employers include pediatric dental benefits to their employees and dependents. Therefore, this coverage must be included unless you can provide proof that you already have pediatric dental benefits through another carrier. Such proof must be included with this application to Medical Mutual. If proof is not received, pediatric dental benefits and the corresponding premiums will be included. If a Medical Mutual Dental Plan is purchased, Pediatric Dental will be included.

Part 2: Reason for waiving coverage: (Check appropriate waiver type)

☐ Covered by spouse/domestic partner or parent's employer coverage

Name of Insurer: _____

☐ Medicare ☐ TRICARE ☐ VA coverage ☐ Medicaid

☐ Individual – My policy was obtained through an exchange **and** I was approved for a subsidy

Name of Insurer: _____

☐ Enrolled in another carrier's group plan offered by this employer

Name of Insurer: _____

☐ Enrolled in another employer's group plan as an employee or retiree

Name of Insurer: _____

☐ Other:_____ ☐ No coverage

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance coverage or group health plan coverage, you may be able to enroll yourself or your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward you or your dependents other coverage). However, you must request enrollment within 30 days after you or your dependent's other coverage ends (or after the employer stops contributing toward other coverage). If you or your dependent either becomes eligible for premium assistance or lose eligibility for coverage under the States Children's Health Insurance Program (SCHIP), you will be able to enroll in this plan. However you must request enrollment within 60 days after such event. 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. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

I have read and understood the above terms:

Current Employer_____ MMO Group Number _____

Print Employee Name _____

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.

Employee Name	Group/Company Name
Social Security #	Group #/Section # (required)

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Section II: ACTION REQUIRED

☐ New Application ☐ COBRA/Continuation ☐ Policy Change

Qualifying event date: _____

Action: (check type of change)

☐ Add dependent to the policy (list dependents in section III)

☐ Delete dependent from policy (list dependents in section III)

☐ Add spouse due to marriage (list Spouse in section III) Date married: _____

☐ Name change (list new name in section III) Former name:_____

☐ Cancel coverage

☐ Other (description) _____

Section III: APPLICANT INFORMATION

Last Name	MI	First Name	
Permanent Residence		City	E-mail Address
County	State	Zip Code	Best Contact # ( )

Employment Status	Marital Status
☐ Active, **Full Time Date of (Re)Hire:** _____ ☐ Retired ☐ COBRA, Expiration Date: _____	☐ Single ☐ Married

Relationship	First Name, MI (and last name, if different)	Social Security Number[2]	Birth Date	Gender	Tobacco User Tobacco User definition – the legal use (other than religious or ceremonial) of any tobacco product on average four or more times per week within no longer than the last six months.
Self				☐ M ☐ F	☐ **Y** ☐ **N**
Spouse				☐ M ☐ F	☐ **Y** ☐ **N**
Domestic Partner[1]				☐ M ☐ F	☐ **Y** ☐ **N**
Dependent Child[2]				☐ M ☐ F	☐ **Y** ☐ **N**
Dependent Child[2]				☐ M ☐ F	☐ **Y** ☐ **N**
Dependent Child[2]				☐ M ☐ F	☐ **Y** ☐ **N**

[1]Refer to Section VII, Number 11, Terms and Conditions, for domestic partner eligibility requirements.

[2]Providing Social Security Number will maximize claims accuracy and expedite processing.

WARNING: Any person who, with the 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.

Employee Name	Group/Company Name
Social Security #	Group #/Section # (required)

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Section IV: OTHER COVERAGE

Medicare Information Are you or any dependent covered by Medicare? ☐ Yes ☐ No If yes, please complete the section below:

Policyholder Name	Medicare Number	Part A Effective Date	Part B Effective Date	Reason for Medicare
				☐ Age ☐ End Stage Renal ☐ Disability, Indicate Reason: _____
				☐ Age ☐ End Stage Renal ☐ Disability, Indicate Reason: _____

Important Notice for Medicare Eligible Individuals: If you are entitled to Medicare and Medicare is your primary coverage, you should enroll in and maintain that coverage, because when Medical Mutual is the secondary payer to Medicare Part B, Medical Mutual's plan will coordinate benefits as if you were covered under Part B, even if you are not. This can result in you being responsible for costs that would have been paid by Medicare. Your broker can assist you with any questions.

(If you are entitled to Medicare because you are 65 and over and your employer employs fewer than 20 employees; or if you are entitled to Medicare due to disability and your employer employs fewer than 100 employees, Medicare will be the primary payer, that is, Medicare must pay benefits before the group health plan pays benefits.)

Continuing Coverage (other than Medicare) Are you or any dependent keeping other health insurance coverage? ☐ Yes ☐ No If yes, please complete the section below:

Policyholder Name	Name and Address of Insurance Company	Policy Number	Effective Date	Coverage Type	Work Status	Policy Type
				☐ Medical ☐ Dental ☐ Hospital Only ☐ Vision ☐ Prescription Drug	☐ Active ☐ Retired	☐ Single ☐ Family

Section V: ABOUT YOUR NEEDS

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

Y	N	
☐	☐	Hearing-impaired (Require use of TDD/TYY 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:_____

Employee Name	Group/Company Name
Social Security #	Group #/Section # (required)

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Section VI: PRODUCTS**

Medical, dental and vision benefits

Your group insurance provided by Medical Mutual may not include all the benefits listed below. Ask your employer for the details about the benefits available to you and your cost (if any).

Medical

Coverage Type (please select one)

☐ Employee
☐ Employee & Spouse/Domestic Partner
☐ Employee + Child(ren)
☐ Family

Health Plan Option (please select one)

Gold Plan Options

☐ Medical Mutual Gold 2000 HSA
☐ Medical Mutual Gold 2520-1000
☐ Medical Mutual Gold 2520-2000

Silver Plan Options

☐ Medical Mutual Silver 1000
☐ Medical Mutual Silver 3000 HSA
☐ Medical Mutual Silver 3530-2000
☐ Medical Mutual Silver 4000 ES-HSA
☐ Medical Mutual Silver 5000 ES-HSA

Bronze Plan Options

☐ Medical Mutual Bronze 3000 HSA
☐ Medical Mutual Bronze 4040-5000
☐ Medical Mutual Bronze 5000 HSA

Dental*

Coverage Type (please select one)

☐ Employee
☐ Employee & Spouse/Domestic Partner
☐ Employee + Child(ren)
☐ Family

Dental Plan Options* (please select one)
(All Plans Include Pediatric Dental)**

☐ Dental Plan 3
☐ Dental Plan 4
☐ Dental Plan 5
☐ Dental Plan 6
☐ Dental Plan 7
☐ Dental Plan 8
☐ Dental Plan 9

Vision*

Coverage Type (please select one)

☐ Employee
☐ Employee & Spouse/Domestic Partner
☐ Employee + Child(ren)
☐ Family

Vision Plan Options* (please select one)

☐ VSP Plan 1
☐ VSP Plan 2

*Dental and Vision plans can be purchased without medical as stand alone products.

**The Affordable Care Act requires that small employers offer include pediatric dental benefits to their employees and dependents. Therefore, this coverage must be included unless you can provide proof that you already have pediatric dental benefits through another carrier. Such proof must be included with this application to Medical Mutual. If proof is not received, pediatric dental benefits and the corresponding premiums will be included in the plan selected above. If a Medical Mutual Dental Plan is purchased, Pediatric Dental will be included.

Employee Name	Group/Company Name
Social Security #	Group #/Section # (required)

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Section VI: PRODUCTS (continued)**

Life and Disability Benefits

A. COVERAGE SELECTION

Your group insurance provided by Consumers Life Insurance Company may not include all the benefits listed below. Ask your employer for the details about the benefits available to you, your cost, (if any), and whether you will be required to submit evidence of insurability.

Employer Paid Plans*

Elect	Waive	Coverage Type
☐	☐	Basic Life and AD&D
☐	☐	Dependent Life
☐	☐	Short-Term Disability
☐	☐	Long-Term Disability

*If employer pays 100% of premium, employee may not waive coverage

Class and Salary Information

Life Class:

Occupation/Job Title:

Current Earnings: $

☐ Hour ☐ Month ☐ Week ☐ Year

Employee Paid Plans**

Elect	Waive	Coverage Type	Amount
☐	☐	**Voluntary Life** (can be chosen in increments of $10,000, to a maximum of $300,000)	$ _____
☐	☐	**Supplemental Life**	$ _____
☐	☐	**Supplemental AD&D**	$ _____
☐	☐	**Dependent Life**	$ _____

B. VOLUNTARY STD PLAN OPTIONS

Plan	Weekly Benefit	Min. Annual Salary	Plan	Weekly Benefit	Min. Annual Salary	Plan	Weekly Benefit	Min. Annual Salary
☐ 1	$100	$7,430	☐ 4	$250	$18,570	☐ 7	$400	$29,715
☐ 2	$150	$11,140	☐ 5	$300	$22,285	☐ 8	$450	$33,430
☐ 3	$200	$14,860	☐ 6	$350	$26,000	☐ 9	$500	$37,145

C. BENEFICIARY DESIGNATION

(For Employee Only: Must be completed if you have applied for Life or AD&D insurance). If two or more primary beneficiaries are named, and you do not list benefit percentages, proceeds will be paid in equal shares to the named primary beneficiaries who survive you. If no primary beneficiary survives you, proceeds will be paid to the contingent beneficiary(ies). If you list benefit percentages, the total must equal 100%. (Employee is the beneficiary of proceeds from spouse or child coverage).

Last Name	First Name	Date of Birth	Relationship	Benefit %
Primary:				
Primary:				
Contingent:				
Contingent:				

Employee Name	Group/Company Name
Social Security #	Group #/Section # (required)

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Section VII: TERMS AND CONDITIONS

I hereby apply to the carrier(s) offering the coverage indicated on this application. I acknowledge that by enrolling in these products, coverage is provided by the following entities (collectively referred to as "Medical Mutual"):

- **Medical Mutual of Ohio® (MMO)**
- **Medical Health Insuring Corporation of Ohio® (MHICO)**
- **Consumers Life Insurance Company® (CLIC**) for life, accidental death and dismemberment, and disability benefits

1. I authorize: (1) payroll deduction(s) and remittance of any required contribution for coverage to Medical Mutual and/or any affiliates or divisions of Medical Mutual; (2) release of information, without limitation, from any medical/medically related facility, prior health insurance carrier, the Medical Information Bureau, Inc. (MIB), prescription history database supplier, pharmacy benefit manager, 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 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. I authorize MMO/CLIC or its reinsurers to make a brief report of my personal health information to MIB.

2. I understand that the participation free life insurance benefits for which I am applying are subject to eligibility questions and I agree that I, as the Applicant, have answered the participation free eligibility questions to the best of my knowledge and belief. I also understand that if I answered "yes" to any of the participation free eligibility questions that I, am NOT eligible for the participation free life insurance benefits.

3. By signing below, I represent and warrant as follows: (a) I have thoroughly read and understand this Health and Life Application and the questions asked herein; (b) I have answered each and every question set forth in this Application; (c) all of my answers to each of the questions are accurate, complete and true and (d) I did not sign a blank or partially completed Application. I agree that Medical Mutual, in it's sole discretion, may rescind my policy on the basis of any material misrepresentation or fraudulent response to any question in this Application. I further agree that if a policy is issued, it will be issued by Medical Mutual in full reliance and in consideration of the information, answers and statements contained herein.

4. I agree that: a) to be eligible for coverage, I must be an active full-time employee as defined by the policy(ies); (b) to be eligible for life and or disability income insurance, I must be actively at work as defined in the group policy. If I am not actively at work on the date my life and/or disability coverage would become effective, my life and/or disability coverage will begin on the day I return to work; and (c) if coverage is issued, it will be based on full reliance on the information contained in this Application.

5. I have read the sales materials and understand the plan benefits, exclusions, and limitations as outlined therein. I acknowledge that the managed care features of this health insurance policy (such as the preferred provider organization network) have been explained to my satisfaction. The applicable certificate or evidence of coverage will determine the rights and responsibilities of covered persons and will govern in the event they conflict with any benefit comparison summary or other description of the plan.

6. No issuance, waiver, modification or change of policy or any of Medical Mutual rules or amendments shall be binding upon Medical Mutual unless it is in writing and signed by an authorized officer of Medical Mutual, as applicable.

7. A permanent ID card will be issued following the final review and acceptance of this Application.

8. I understand and agree that I am solely and exclusively responsible for the truth, accuracy and completeness of all of the answers contained in this Application. I understand and agree that no agent or broker who may be assisting in the completion of this Application has any authority: (a) to waive any answer or any portion of any answer to any question on this Application or any information Medical Mutual requests; (b) to advise me that I am not obligated to disclose any condition of which I am aware concerning my health or the health of any dependent included on the Application; (c) to make any representation concerning health benefits that are inconsistent with, or different from, any written information provided by Medical Mutual; or (d) to bind Medical Mutual in any way by making any statement, promise or representation that is not set out in writing in this Application or regarding eligibility, benefits or issuance of a policy; (e) to answer any questions in, or insert any information on, this Application on my behalf; or (f) to approve coverage.

Employee Name	Group/Company Name
Social Security #	Group #/Section # (required)

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Section VII: TERMS AND CONDITIONS (continued)

9. 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, payment related, 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 (including medical, dental, and pharmacy) information is disclosed pursuant to this authorization, it may be redisclosed 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. To revoke this authorization, I must do so in writing and send my written revocation to Medical Mutual's Privacy Office. The revocation will not apply to information that has already been released in response to this authorization. The revocation may adversely affect my application, a claim or a pending insurance action. The revocation will become effective after it is received by Medical Mutual Privacy Office. Your refusal to authorize the release of this information may impact your ability to enroll in Medical Mutual's health plan if Medical Mutual needs the information to determine your eligibility for coverage.

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

11. If I am applying for coverage for my domestic partner, I represent and warrant that I and my domestic partner: 1) cohabit and reside together in the same residence and have done so for at least six months and intend to do so indefinitely; 2) are engaged in an exclusive and committed relationship and are financially interdependent; 3) are both at least 18 years of age and are each other's sole domestic partner; 4) are not married or separated from anyone else; 5) have not had another domestic partner within six months of establishing the current domestic partnership; 6) are not related by blood; and 7) are not in this relationship solely for the purpose of obtaining insurance benefits.

I am signing this Application on my own behalf and on behalf of all listed dependents. An unaltered copy of this authorization is as valid as the original.

_____ _____

Applicant's or Guardian's Signature Date

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