MEDICAL MUTUAL OF OHIO®
YOUR HEALTHCARE PARTNER SINCE 1934

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CONSUMERS LIFE INSURANCE COMPANY®
A MEDICAL MUTUAL OF OHIO COMPANY

Medical Mutual of Ohio Employee Application/Change Form
For Individuals in Groups with 20+ Eligible Employees

INSURANCE 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®
☐ Life/Disability through Consumers Life Insurance Company

☐ 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 coverage. Insurance company name: _____

B. Current health coverage status: I have: (Check one)

☐ No coverage

☐ Other coverage: _____

☐ Coverage through my spouse's employer. Company name: _____

C. 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 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 insurance coverage, you may be able to enroll yourself or your dependents in this plan if: (1) you or your dependents lose eligibility for that other coverage or reach the plan's lifetime benefit maximum; or (2) the employer stops contributing towards your or your dependents' other coverage. However, you must request enrollment within 31 days after the applicable event occurs (other coverage ends, lifetime maximum is met, or employer's contribution ends). If you or your dependent either become eligible for premium assistance or lose eligibility for coverage under the State Children's Health Insurance Program (SCHIP), you will also be able to enroll in this plan. However, you must request enrollment within 60 days after such an event. 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: _____ MMO Group Number: _____

Print Employee Name: _____ Employee Social Security Number: _____

Print Spouse Name: _____ Spouse Social Security Number: _____

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

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

1. ACTION REQUESTED

☐ **New Policy Application** or ☐ **COBRA/Continuation**

Requested Effective Date: _____ (Optional)

Select Coverage: (Check all that apply)

- ☐ Health Product Name: _____
- ☐ Drug Product Name: _____
- ☐ Dental Product Name: _____
- ☐ Vision Product Name: _____
- ☐ Life Complete Life and Disability Benefit section

☐ **Policy Change**

Requested Date of Change: _____ (Optional)

Action: (Check the type of change)

- ☐ Address change (Enter new address in Section 2)
- ☐ Add dependent to policy (List dependent(s) in Section 3)
- ☐ Delete dependent from policy (List dependent(s) in Section 3)
- ☐ Add spouse due to marriage. Date Married: _____ (List spouse in Section 3)
- ☐ Name change. Former Name: _____
- ☐ Cancel coverage
- ☐ Other

2. EMPLOYEE INFORMATION

Last Name	First Name	MI	Social Security#	Date of Birth (m/d/y)	Gender ☐M ☐F

Employment Status

- ☐ Active, **Full Time Date of (Re)Hire:** _____
- ☐ Retired
- ☐ COBRA, Expiration Date: _____

Marital Status

- ☐ Single ☐ Separated ☐ Widowed
- ☐ Married, Date Married: _____
- ☐ Divorced, Date Divorced: _____

Job Title	Department #

Home Address	City	State	Zip Code

Email Address	Home Phone Number	Primary Care Physician (HMO & Select Only)

3. COVERED DEPENDENTS

Relationship	First Name	Last Name (if different)	Date of Birth	Social Security #	Gender	Primary Care Physician (HMO & Select only)
Spouse					☐M ☐F	
☐Child[1] ☐Adopted[2] ☐Stepchild ☐Other[2]					☐M ☐F	
☐Child[1] ☐Adopted[2] ☐Stepchild ☐Other[2]					☐M ☐F	
☐Child[1] ☐Adopted[2] ☐Stepchild ☐Other[2]					☐M ☐F	
☐Child[1] ☐Adopted[2] ☐Stepchild ☐Other[2]					☐M ☐F	

[1] If over limiting age, Student or Disability Certification form must be attached to this application
[2] Legal Documentation (court decree, guardianship papers, etc.) must be attached to this application

Employee Name	Group/Company Name
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4. 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: _____

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

Prior or Ending Coverage Do you or any dependent have any prior or ending health insurance? ☐ Yes ☐ No
If yes, please complete the section below:

- What date did your most recent health insurance become effective? _____
- What date did/will this health insurance terminate? _____
- Please indicate the carrier name for the above health insurance: _____

5. MEDICAL HEALTH QUESTIONNAIRE

A. MEDICAL CONDITIONS

Have you or any listed dependent been treated for, diagnosed as having, or have been recommended during the last 5 years for future surgery, diagnostic testing (excluding HIV and AIDS) or medical treatment or thought you should seek medical advice for any of the following conditions? If yes, explain in 5c.

	Y	N		Y	N	
1.	☐	☐	Alcohol/Drug Dependency	☐	☐	10. Lung Disease
2.	☐	☐	Auto-Immune Disorder	☐	☐	11. Depression/Mental Disorder
3.	☐	☐	Blood/Clotting Disorder	☐	☐	12. Muscle/Skeletal Disorder
4.	☐	☐	Cancer	☐	☐	13. Nervous System Disorder
5.	☐	☐	Circulatory Disorder	☐	☐	14. Spinal/Disc Disorder
6.	☐	☐	Diabetes/Endocrine	☐	☐	15. Transplant
7.	☐	☐	Hypertension/Heart Disease	☐	☐	16. Smoker
8.	☐	☐	Infertility	☐	☐	17. Stomach/Bowel
9.	☐	☐	Kidney Disease	☐	☐	18. Other _____

B. MEDICAL QUESTIONS

	Y	N	
1.	☐	☐	Have you or any dependent been hospitalized, had surgery, been advised to have surgery or seek treatment for any medical condition during the last 5 years? (Explain in 5c)
2.	☐	☐	Are you or any dependent currently taking any prescription or over the counter medications? (Explain in 5c)
3.	☐	☐	Has ANY PERSON TO BE COVERED ever been diagnosed as having AIDS, or an AIDS related condition or had a positive test result on an HIV test?
4.	☐	☐	Are you or any dependent currently pregnant?

If yes: Name:_____ Due Date:_____

Is this pregnancy considered high risk? ☐ Y ☐ N

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

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C. EXPLANATION (Explain all *yes* responses from Medical Conditions and Medical Questions here)

Name	Condition Number	Treatment Date (From-To)	Diagnosis/Treatment/Medication/Dosage (Be specific)	Recovered Y N
John Doe	*e.g. A5*	*10/2005-3/2007*	*Skin Cancer/Radiation/Medication Xxxxxxxxxx*	☑ ☐
				☐ ☐
				☐ ☐
				☐ ☐
				☐ ☐
				☐ ☐
				☐ ☐

Attach a separate sheet if additional space is required.

6. 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:_____

7. PRE-EXISTING CONDITION NOTICE

(HMO PLANS ARE NOT SUBJECT TO PRE-EXISTING CONDITION LIMITATIONS. THEREFORE, THIS SECTION DOES NOT APPLY TO HMO PLANS.)

The following information is attached to and incorporated into your application to Medical Mutual of Ohio:

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 having 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.

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

8. CONSUMERS LIFE INSURANCE COMPANY

A. SELECT COVERAGE

If your employer offers these additional coverages, please check the coverages which you would like to enroll:

- ☐ Basic Life and AD&D (Complete sections B and C below)
- ☐ Voluntary Life, Indicate Amount: $ _____ ($10,000 to $300,000) (Complete section C below)
- ☐ Dependent Life
- ☐ Long Term Disability (Complete section B below)
- ☐ Short Term Disability (Complete section B below)
- ☐ Voluntary Short Term Disability (Complete section B and D below)

B. GENERAL INFORMATION

Class: Annual Salary (Excluding bonuses, overtime and other forms of extra pay):

ORIGINAL DATE OF HIRE	OCCUPATION/JOB TITLE

C. BENEFICIARY INFORMATION

BENEFICIARY DESIGNATION: (For Employee Only: Must be completed if you have applied for life and/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 beneficiaries survives you, proceeds with be paid to the contingent beneficiary(ies). If you

LAST NAME	FIRST NAME	DATE OF BIRTH	RELATIONSHIP	BENEFIT %
Primary				%
Primary				%
Contingent				%
Contingent				%

D. 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

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

9. 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) for non-HMO health plans
- Medical Health Insuring Corporation of Ohio (MHICO) for HMO health plans
- Consumers Life Insurance Company® (CLIC) for life, accidental death and dismemberment, and disability benefits

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, 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 providea 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.

By signing below, I represent and warrant as follows: (a) I have thoroughly read and understand this 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 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; (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. All contract terms must be in writing and signed or accepted in writing by an authorized representative of Medical Mutual to be binding on Medical Mutual. 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.

I understand and agree that I am responsible for disclosing all information required by this Application, including, but not limited to, all health conditions and diagnoses of which I am aware. I understand and agree that Medical Mutual has the exclusive right to determine whether a particular condition or diagnosis is significant, that I do not have the right to evaluate whether a condition or diagnosis should or should not be disclosed on this Application and that I am obligated to disclose even those conditions or diagnoses that I do not believe are significant or important.

I agree that: (a) any untrue or incomplete information, statement or answers on this Application (whether or not intentional), can result in denial of a claim or rescission of coverage and may subject me to legal action by Medical Mutual; (b) to be eligible for coverage, I must be an active full-time employee as defined by the policy(ies); (c) 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 income coverage would become effective, my life and/or disability coverage will begin on the day I return to work; (d) if coverage is issued, it will be based on full reliance on the information contained in 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 (including medical, dental, and pharmacy) 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. 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's Privacy Office.

continued on next page

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

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9. TERMS AND CONDITIONS (continued)

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.

I understand that if I choose HMO coverage, the HMO restricts enrollee access to health care providers. Benefits are payable only for covered services that are provided by a Network Physician, unless otherwise approved by MHICO. This applies to all covered services except Emergency Services. The HMO will furnish you with a list of plan physicians and plan facilities upon enrollment and/or request. Right of Cancellation: If you are obligated to share in the cost of the coverage, you may cancel this Application within 72 hours after you have signed this Application. Cancellation will occur when written notice is given to MHICO. Notice of cancellation shall be considered given when you mail a letter to MHICO.

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. 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.I understand that I should not cancel any current insurance coverage until I receive an approval letter and insurance certificate from Medical Mutual.

Employee Signature	Date	Your Spouse's Signature (If applying for coverage)	Date

WARNING: Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against any insurer, submits any application or files a claim containing a false or deceptive statement is guilty of insurance fraud. (Ohio Revised Code Section 3999.21)

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