Employer Group Enrollment Application/ Participation Agreement/Change Form For Groups with 1-99 Eligible Employees

MEDICAL MUTUAL OF OHIO®

☐ initial enrollment ☐ change

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1. Group/Company Information

Business Name				
Has this business ever been known by another name? ☐Yes ☐No If yes, what name(s)?			MMO Membership # (if applicable)	
Business Address (No P.O. Boxes)			Billing Address	
City	County	State	Zip Code	Business Phone Number
Chief Executive Officer	Billing Contact		Business Fax Number	
Business E-Mail	Number of years in business (If less than one year specify the date the business started.)			
Type of Business (be specific)	SIC Code		Employer/Federal Tax ID #	
Dun and Bradstreet # _____	Has group ever applied with MMO? ☐ Yes ☐ No If so, when?_____			

Is the employer contribution at least 50% of each contract? ☐ Yes ☐ No

Is the plan subject to ERISA? ☐ Yes ☐ No (Check the applicable box below)

- ☐ Government entity (i.e., city, county, township, public school district)
- ☐ Church plan
- ☐ Group of one (self employed)
- ☐ Other: _____

Do you have any affiliations with other companies or unions (include parent, subsidiary, joint venture, etc...) ?
☐ Yes ☐ No If yes, please describe.

If yes, do any of these affiliates qualify as a single employer under subsection (b), (c), (m), or (o) of the Internal Revenue Code Section 414? If yes, please give the legal names, federal tax ID# and number of employees.

2. Enrollment Criteria

Eligible Employee Definition: What is the minimum # of hours to be worked per week for employees to be considered eligible for insurance benefits*_____

Probationary Period for New Hire Benefits
- ☐ Date of Hire
- ☐ First of month following Date of Hire
- ☐ 30 days following Date of Hire
- ☐ First of month following 30 days
- ☐ 60 days following Date of Hire
- ☐ First of month following 60 days
- ☐ 90 days following Date of Hire

Probation Period for Rehire
- ☐ Same as above ☐ Other_____

Waive probationary period for initial enrollment?
☐ Yes ☐ No

*Minimum must be within 20 – 25 hours per week, for full time eligibility for groups with 50 or fewer eligible employees.
**Including owners, officers and partners who receive compensation from the company, reported on a tax form other than a 1099.

Participation	Active**	COBRA	Retired**
Total number of current employees (part time & full time)			
Total number of eligible employees			
Number of eligible employees applying for coverage			
Total number of ineligible employees			

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

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3. PRODUCTS**

Medical, dental and vision benefits

(Groups with 51 or more eligible employees are required to sign a separate benefit highlight form reflecting benefits desired. Therefore, this product selection area is not required to be completed.)

Health Plan Option

Platinum Plan Options
☐ Medical Mutual 2020-250
☐ Medical Mutual Platinum 2020-500

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

Silver Plan Options
☐ Medical Mutual Silver 1000
☐ Medical Mutual Silver 3530-2000

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

Summit Select***
☐ Medical Mutual Summit Select Gold 1000

Dental Plan Options*
(All Plans Include Pediatric Dental)**
☐ Dental Plan 1
☐ Dental Plan 2
☐ Dental Plan 3
☐ Dental Plan 4
☐ Dental Plan 5
☐ Pediatric Dental 2

Vision Plan Option*
☐ Eyemed Plan 1

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

**The Affordable Care Act requires that small employers offer pediatric dental benefits to their employees and dependents. Therefore, this coverage must be included unless proof of pediatric dental benefits through another carrier is provided. Such proof must be included with this application to Medical Mutual. If proof is not received, pediatric dental benefits (Pediatric Dental 1) 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.

***Available for groups domiciled in Summit County

Employer Funding:

Is any part of the employee's or dependent's deductible being funded by the employer or from an employer-established account? ☐ Yes ☐ No If so, how much? Single: _____ Family: _____

Does the employer fund first? ☐ Yes ☐ No

4. Life, AD&D, Dependent Life and Short-Term Disability

☐ Yes I am electing life and/or short-term disability coverage in accordance with proposal number _____, incorporated by reference in and made part of this application for all purposes.
If multiple plans are indicated on the proposal, indicate plan option elected _____.

The requested effective date will be as stated in the above-mentioned proposal, unless indicated below:

_____.

If the Company approves this application, a policy will be issued. The applicant agrees that acceptance of the Policy will be approval of the Policy terms.

Participation-free coverage
☐ Yes, I am electing participation-free Voluntary Life and AD&D
☐ Yes, I am electing participation-free Voluntary Life, AD&D and short-term disability.
If participation-free, voluntary short-term disability is elected, indicate the plan: _ 1/8/13 _ 1/8/26

Waiting period is identical to medical probationary period, unless indicated below:
☐ None
☐ First of month following completion of _____ days
☐ Other _____

Employees working less than 20 hours per week are not eligible for coverage. If different than 20 hours, please indicate number of hours:_____

Employer contribution percentages (%) for all products are stated in the proposal, unless indicated below:

Product	%	Product	%
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Group Long-Term Disability

☐ Yes I am electing group long-term disability coverage in accordance with proposal number _____, incorporated by reference in and made part of this application for all purposes.
If multiple plans are indicated on the proposal, indicate plan option elected _____.

The requested effective date will be as stated in the above-mentioned proposal, unless indicated below:

_____.

If the Company approves this application, a policy will be issued. The applicant agrees that acceptance of the Policy will be approval of the Policy terms.

Prior carrier: _____
(Prior carrier must be listed and a copy of the prior policy included for **continuity of coverage** to apply.)

Termination date of prior policy: _____

Waiting period – present employees: _____

Waiting period – future employees: _____

Employees working less than 30 hours per week are not eligible for coverage. If different than 30 hours, please indicate number of hours: _____ .

Contribution:
Employer _____% Employee _____% ☐Pre-tax dollars ☐Post-tax dollars

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5. Current and Prior Carrier History

List all carriers used for all product lines of insurance offered to the employees for the past 5 years. If there are no carriers, indicate NONE. (list current carrier first)

Carrier Name	Continuing Coverage	Benefits*	Dates From	Dates To	Current Rates** Emplye	Current Rates** Spouse	Current Rates** Child	Current Rates** Family	Renewal Rates** Emplye	Renewal Rates** Spouse	Renewal Rates** Child	Renewal Rates** Family
	☐											
	☐											
	☐											

*Examples: Traditional, PPO, HMO, Self Insured, etc...
**If you're age banded with current carrier, please provide most recent billing statement.

6. Validations

Groups completing the Employer Risk Assessment Form may skip Sections A & B.

A. Serious Medical Conditions: As an employer are you aware of any employee or dependent of an employee, including those not enrolling for coverage, who has been diagnosed or treated for a serious health problem such as AIDS, HIV positive status, Alzheimer Disease, Cancer, Diabetes, Heart Attack or Heart Disease, Hemophilia, Kidney Disease, Mental Illness or Substance Abuse? _Yes _No If yes, provide details below. (Attach separate sheet of paper if needed)

Patient Name	Aggregate Dollar Amount of Claims	Dates of Service	Describe Illness or Condition

B. Has anyone within the past 24 months been hospitalized, institutionalized or missed work due to any disability or work related injury? ☐Yes ☐No If yes, provide details below.

Patient Name	Describe Illness or Condition

C. Is anyone currently COBRA eligible/enrolled? ☐Yes ☐No If yes, provide details below.

Name	Social Security #	Beginning Date	Expiration Date	Qualifying Event

D. Are there any retirees who meet the eligibility requirements AND are members of a formal retirement program? ☐Yes ☐No If yes, provide details below.

Name	Social Security #	Age at Retrmnt	Date of Rtrmnt	Date of Hire	Avg. Hrs. Worked Per Week Prior to Rtrmnt

7. Terms and Conditions

I, as the undersigned employer or other eligible membership organization duly organized under the laws of the State of Ohio, hereby apply to the carrier(s) offering the coverage indicated on this Application. I acknowledge that by applying for 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 understand, acknowledge and agree to the following:

- **This Employer Group Enrollment Application, Participation Agreement and Change Form ("Application") is not a contract for benefits. I should continue my current coverage until I am notified in writing that Medical Mutual has accepted this Application.**
- If this Application is accepted by Medical Mutual, the actual benefits will be specified in the group contract(s) and that said benefits will take effect on the date specified in a communication from the applicable carrier(s) underwriting my group coverage.
- For all groups, each employee not enrolling must complete the waiver section of the applicable employee application. For groups of 1-50 employees: Each employee applying for any product offered by Medical Mutual must complete all sections of the applicable employee application.
- Only my full-time employees are eligible for coverage. All individuals who apply for insurance coverage from Medical Mutual must be full-time, common-law employees, drawing a regular paycheck, whose compensation is reported on IRS Form W-2. Independent contractors are not eligible for coverage. For life and/or disability benefits only, being Actively at Work (as described earlier in this Application and defined in the group policy) is a requirement for coverage. If an employee is not Actively at Work on the day his coverage would otherwise be effective, the effective date of his life and/or disability coverage will be the date of his return to Active Work. If an employee does not return to Active Work, he will not be covered.
- To be eligible for coverage, I must comply with all applicable laws of the State of Ohio. By applying for coverage, I agree that Medical Mutual may, from time to time, verify my compliance with the underwriting eligibility or participation standards of the pertinent program. I agree to provide payroll records if requested by Medical Mutual or any other carrier to verify my compliance.
- Any untrue or incomplete information, statements or answers on this Application (whether or not intentional) or engaging in any fraudulent conduct, deceptions or misrepresentation relating to any application, coverage, claim or usage of a carrier identification card, can result in denial of a claim or rescission of coverage for me or any group member, and may subject me or any group member to legal action by Medical Mutual. I have a duty to notify Medical Mutual of any changes to the information contained in this Application.
- Approval and acceptance of this Application and individual employee applications are subject to Medical Mutual's underwriting guidelines, as permitted by law. Checking the boxes does not cause automatic enrollment. Medical Mutual must approve this Application.
- This Application shall be made part of the policy for which application is made and supersedes any previous applications for this group coverage.
- By signing this Application, I represent that this group or company is not an entity that has been formed primarily to obtain insurance coverage, and it does not permit membership in this group or company solely for the purpose of obtaining insurance coverage.
- I authorize Medical Mutual to obtain information from prior carriers to determine existence of pre-existing conditions. Prior carriers are authorized to release such information to Medical Mutual upon receipt of a copy of this Application. Medical Mutual collects this data as a service to you.

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7. Terms and Conditions (continued)

- No agent or broker has the authority to: (1) bind Medical Mutual by making promises regarding eligibility, benefits, or the issuance of a policy; (2) waive any answer or any portion of any answer to any question on this Application or any information Medical Mutual requests; (3) approve coverage; (4) make or alter any contract on behalf of Medical Mutual; or (5) waive or alter any of Medical Mutual's other rights or requirements. 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 group or company hereby appoints the Secretary of Medical Mutual of Ohio as its proxy, with power of substitution, to act for and on its behalf at any and every annual meeting or any special meeting of the members of Medical Mutual of Ohio. The group or company authorizes its proxy to vote and act for and on behalf of the member at such meeting as fully and to the same extent as the member could do if present thereat. This proxy shall continue in force until ten years from the date hereof unless sooner revoked by a notice in writing signed by the group and delivered to Medical Mutual of Ohio.
- Group life, AD&D and disability benefits are only available through a trust for a business of one.

8. Authorized Signature (Please print)

Business Name	Name (print)	Title
Authorized Signature		Date
Broker Signature (if applicable)	Broker Name (print) (if applicable)	
Commissions Payable to Federal Tax ID #	Royal Advantage Broker	

WARNING: 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)

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Business of One SuperMed Life Trust Participation Agreement

This Participation Agreement relates to participation in the following group Insurance trust policy:

1. Name of Policyholder: The Trustee of the SuperMed Life Trust
   Situs of Trust: Strongsville, Ohio
2. Group Policy Number: _____
3. Effective Date of Policy: _____
4. Name of Insurance Company: Consumers Life Insurance Company

Request for Participation:
The undersigned employer or other eligible membership organization ("Participating Employer") hereby applies to become a Participant in the group insurance Trust identified above. The undersigned Participating Employer acknowledges that a copy of the group insurance policy is maintained in Consumer Life Insurance Company's business office in Strongsville, Ohio and is subject to examination by participating employers and employees. The undersigned Participating Employer acknowledges that participation in the Trust will not commence unless the Participating Employer receives written notice of approval from Consumers Life Insurance Company's home office.

Agreement Concerning Participation:
The Participating Employer agrees that, upon its acceptance by the Trustee for participation in the Trust and subject to approval by Consumers Life Insurance Company for insurance purposes, it will, so long as such participation continues, fully comply with all obligations applicable to participating employers under the Trust as set forth therein. The Participating Employer understands that the insurance coverages under the group insurance policy will be only as provided for under the policy issued to the Trustee as the Policyholder. The undersigned acknowledges that the Trustee is not an insurer, and has no obligations regarding payment of premiums or handling of claims for the insurance provided under the group insurance policy issued to it as policyholder.

Acceptance by Participating Employer

_____
Employer Name

_____
Signature

_____
Title Date