



MEDICAL MUTUAL OF OHIO®
Your healthcare partner since 1934

Employee Application & Change Form

Individuals in Groups with
20+ Eligible Employees

 **CONSUMERS LIFE
INSURANCE COMPANY®**
A MEDICAL MUTUAL OF OHIO® Company



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
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 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.

I have read and understand the above terms:

Current Employer:

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.

Employee Name
Social Security #

Group #
Section # (required)



1. ACTION REQUESTED

<input type="checkbox"/> New Policy Application or <input type="checkbox"/> COBRA/Continuation Requested Effective Date: _____ (Optional) Select Coverage: (Check all that apply) <input type="checkbox"/> Health Product Name: _____ <input type="checkbox"/> Drug Product Name: _____ <input type="checkbox"/> Dental Product Name: _____ <input type="checkbox"/> Vision Product Name: _____ <input type="checkbox"/> Life Complete Life and Disability Benefit section	<input type="checkbox"/> Policy Change Requested Date of Change: _____ (Optional) Action: (Check the type of change) <input type="checkbox"/> Address change (Enter new address in Section 2) <input type="checkbox"/> Add dependent to policy (List dependent(s) in Section 3) <input type="checkbox"/> Delete dependent from policy (List dependent(s) in Section 3) <input type="checkbox"/> Add spouse due to marriage. Date Married: _____ (List spouse in Section 3) <input type="checkbox"/> Name change. Former Name: _____ <input type="checkbox"/> Cancel coverage <input type="checkbox"/> Other
---	---

2. EMPLOYEE INFORMATION

Last Name	First Name	MI	Social Security#	Date of Birth (MM/DD/YYYY)	Gender <input type="checkbox"/> M <input type="checkbox"/> F
Employment Status <input type="checkbox"/> Active, Full Time Date of (Re)Hire: _____ <input type="checkbox"/> Retired <input type="checkbox"/> COBRA, Expiration Date: _____		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married, Date Married: _____ <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed			
Home Address		City	State	Zip Code	
Email Address		Home Phone Number	Primary Care Physician (HMO and Select Only)		

3. COVERED DEPENDENTS

Relationship	First Name	Last Name (if different)	Social Security #	Date of Birth	Gender	Primary Care Physician (HMO and Select only)
Spouse					<input type="checkbox"/> M <input type="checkbox"/> F	
<input type="checkbox"/> Child ¹ <input type="checkbox"/> Adopted ² <input type="checkbox"/> Stepchild ¹ <input type="checkbox"/> Other ²					<input type="checkbox"/> M <input type="checkbox"/> F	
<input type="checkbox"/> Child ¹ <input type="checkbox"/> Adopted ² <input type="checkbox"/> Stepchild ¹ <input type="checkbox"/> Other ²					<input type="checkbox"/> M <input type="checkbox"/> F	
<input type="checkbox"/> Child ¹ <input type="checkbox"/> Adopted ² <input type="checkbox"/> Stepchild ¹ <input type="checkbox"/> Other ²					<input type="checkbox"/> M <input type="checkbox"/> F	
<input type="checkbox"/> Child ¹ <input type="checkbox"/> Adopted ² <input type="checkbox"/> Stepchild ¹ <input type="checkbox"/> Other ²					<input type="checkbox"/> M <input type="checkbox"/> 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

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
				<input type="checkbox"/> Age <input type="checkbox"/> End Stage Renal <input type="checkbox"/> Disability, Indicate Reason: _____
				<input type="checkbox"/> Age <input type="checkbox"/> End Stage Renal <input type="checkbox"/> 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
				<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

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: _____

Employee Name
Social Security #

Group #
Section # (required)



5. MEDICAL HEALTH QUESTIONNAIRE

A. MEDICAL CONDITIONS

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

Y N 1. <input type="checkbox"/> <input type="checkbox"/> AIDS/AIDS-Related Complex (Diagnosed with) 2. <input type="checkbox"/> <input type="checkbox"/> Alcohol/Drug Dependency 3. <input type="checkbox"/> <input type="checkbox"/> Auto-Immune Disorder 4. <input type="checkbox"/> <input type="checkbox"/> Blood/Clotting Disorder	Y N 5. <input type="checkbox"/> <input type="checkbox"/> Cancer 6. <input type="checkbox"/> <input type="checkbox"/> Circulatory Disorder 7. <input type="checkbox"/> <input type="checkbox"/> Diabetes/Endocrine 8. <input type="checkbox"/> <input type="checkbox"/> Heart Disease 9. <input type="checkbox"/> <input type="checkbox"/> Infertility	Y N 10. <input type="checkbox"/> <input type="checkbox"/> Kidney Disease 11. <input type="checkbox"/> <input type="checkbox"/> Lung Disease 12. <input type="checkbox"/> <input type="checkbox"/> Mental Health Disorder 13. <input type="checkbox"/> <input type="checkbox"/> Muscle/Skeletal Disorder 14. <input type="checkbox"/> <input type="checkbox"/> Nervous System Disorder	Y N 15. <input type="checkbox"/> <input type="checkbox"/> Spinal/Disc Disorder 16. <input type="checkbox"/> <input type="checkbox"/> Transplant 17. <input type="checkbox"/> <input type="checkbox"/> Smoker 18. <input type="checkbox"/> <input type="checkbox"/> Other _____
---	--	--	--

B. MEDICAL QUESTIONS

- Y N
- Have you or any dependent been hospitalized, had surgery, been advised to have surgery or seek treatment for any medical condition? (Explain in 5c)
 - Are you or any dependent currently taking any prescription or over the counter medications? (Explain in 5c)
 - Are you or any dependent currently pregnant?

If yes: Name: _____ Due Date: _____ Is this pregnancy considered high risk? Y N

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

Name	Diagnosis	Treatment Date (From-To)	Treatment/Medication/Dosage (Be specific)	Recovered Y N
John Doe	Skin Cancer	10/2005-3/2007	Radiation/Medication Xxxxxxxx	<input checked="" type="checkbox"/> <input type="checkbox"/>
				<input type="checkbox"/> <input type="checkbox"/>
				<input type="checkbox"/> <input type="checkbox"/>
				<input type="checkbox"/> <input type="checkbox"/>
				<input type="checkbox"/> <input type="checkbox"/>
				<input type="checkbox"/> <input type="checkbox"/>
				<input type="checkbox"/> <input type="checkbox"/>

Attach a separate sheet if additional space is required.

Employee Name
Social Security #

Group #
Section # (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

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
Social Security #

Group #
Section # (required)



8. LIFE AND DISABILITY BENEFITS

A. COVERAGE SELECTION

Your group insurance program 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.

Y	N	Basic Coverage(s)	Add/Delete	Total Amount of Coverage Applied
<input type="checkbox"/>	<input type="checkbox"/>	Basic Life		
<input type="checkbox"/>	<input type="checkbox"/>	Basic AD&D		
<input type="checkbox"/>	<input type="checkbox"/>	Dependent Life		
<input type="checkbox"/>	<input type="checkbox"/>	Short Term Disability		
<input type="checkbox"/>	<input type="checkbox"/>	Supplemental Life		
<input type="checkbox"/>	<input type="checkbox"/>	Supplemental AD&D		

B. CLASS AND SALARY INFORMATION

Class:	Earnings: <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annual	Occupation/Job Title:
\$ _____		

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 Application & Change Form

Medical Mutual of Ohio
2060 East Ninth Street
Cleveland OH 44115-1355

Visit MedMutual.com.