



**EMPLOYEE
APPLICATION and CHANGE FORM**
for individuals in
Groups up to 9 Eligible



INSTRUCTIONS

- ALWAYS PRINT CLEARLY USING A BLUE OR BLACK PEN (NO HIGHLIGHTERS)
- ALWAYS PUT SUBSCRIBER ID NUMBER AND GROUP NUMBER ON APPLICATION.
- NEW HIRES, LATE ENTRANTS, AND DEPENDENT ADDITIONS MUST COMPLETE THE APPLICATION AND MEDICAL HISTORY QUESTIONNAIRE.
- OTHER CHANGES COMPLETE ONLY AREA THAT IS CHANGING E.G: DROPPING DEPENDENTS, ADDRESS CHANGE, PHYSICIAN CHANGE, PRODUCT CHANGE...
- IF WAIVING COVERAGE COMPLETE WAIVER AREA.

(Please Print)

ABOUT YOUR NEEDS

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

- _____ Hearing-impaired (require use of TDD/TTY 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 _____

• If you **do not** want any coverage OR if you reject **some** of the coverage options but accept **others**, complete this waiver...

WAIVER

Check One Box in Section A and Complete Sections B and C.

A. Waived Coverages: I do NOT want...(Check one)

- HEALTH and LIFE/DISABILITY through Medical Mutual of Ohio (MMO) and MLI
- HEALTH through MMO
- LIFE/DISABILITY through MLI
- Health through MMO for the following dependents only: (Remember to complete the rest of this application)

1) _____ 2) _____ 3) _____ 4) _____ 5) _____

B. Current Health Coverage Status: I have...(Check one)

- Coverage through my Current Employer: Other Insurance Company Name: _____
- Coverage through my Spouse's Employer: _____
- | | | |
|--------------------------------------|--|--------------|
| Spouse's Company Name | Spouse's Name | Spouse's SS# |
| <input type="checkbox"/> No coverage | <input type="checkbox"/> Other coverage: _____ | |

C. Authorization: The terms of this waiver are explained in Section 8 of this application. I have read and understand those terms.

Current Employer/Company Name: _____

Print Employee Name: _____ Employee Social Security #: _____

Print Spouse Name: _____ Spouse Social Security #: _____

Signature of Employee: _____ Date: _____

WARNINGS:

Any person who, with 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. (Ohio Revised Code Section 3999.21)

If you or your family members are covered by more than one health care 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)

HEALTH AND LIFE APPLICATION / POLICY CHANGE

GROUP # _____ SECTION _____

1. (Please Print) ABOUT YOU AND YOUR JOB...

YOUR LAST NAME		YOUR SOCIAL SECURITY NUMBER		COMPANY NAME/EMPLOYER	
YOUR FIRST NAME	M.I.	YOUR DATE OF BIRTH	SEX (M or F)	OCCUPATION/JOB TITLE	EMPLOYEE/CLOCK #
YOUR STREET ADDRESS		E MAIL ADDRESS		DEPARTMENT NAME	PAYROLL LOCATION/DEPT. #
CITY	STATE	ZIP CODE		FULL TIME DATE OF (RE)HIRE	EMPLOYMENT STATUS <input type="checkbox"/> ACTIVE <input type="checkbox"/> RETIRED <input type="checkbox"/> COBRA
HOME PHONE NUMBER	MARITAL STATUS: <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED	DATE MARRIED		BUSINESS PHONE	COBRA EXPIRATION DATE

2. (Please Print) WHAT YOU WANT DONE...

<p>A) NEW POLICY APPLICATION</p> <p>1. Type of Coverage:</p> <p>PRIMARY COVERAGE: (check only one)</p> <p><input type="checkbox"/> SuperMed Classic <input type="checkbox"/> SuperMed Share</p> <p><input type="checkbox"/> SuperMed Plus</p> <p><input type="checkbox"/> SuperMed Choice Options (refer to page 4)</p> <p>ADDITIONAL COVERAGE(S): (check all that apply)</p> <p><input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life only</p> <p>2. Who Do You Want Covered?</p> <p><input type="checkbox"/> You Only <input type="checkbox"/> You and One Other Person <input type="checkbox"/> You and Your Family</p> <p>Medicare Supplement For: <input type="checkbox"/> You <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent</p>	<p>B) CHANGE TO AN EXISTING POLICY</p> <p>1. Date of Change: ___/___/___ 2. Requested Effective Date: ___/___/___</p> <p>3. Action (Check the Type of Change)</p> <p><input type="checkbox"/> ADD DEPENDENT TO POLICY (LIST DEPENDENTS IN SECTION 3 BELOW)</p> <p><input type="checkbox"/> DELETE DEPENDENT FROM POLICY (LIST DELETED DEPENDENTS IN SECTION 3 BELOW)</p> <p><input type="checkbox"/> BENEFIT CHANGE (INDICATE CHOICE TO THE IMMEDIATE LEFT UNDER SECTION A)</p> <p><input type="checkbox"/> PRIMARY CARE PHYSICIAN/LOCATION CHANGE (INDICATE CHANGE IN SECTION 3 BELOW)</p> <p><input type="checkbox"/> NAME CHANGE: FORMER NAME: _____</p> <p><input type="checkbox"/> TERMINATED EMPLOYMENT <input type="checkbox"/> DECEASED</p> <p><input type="checkbox"/> REQUESTED CANCELLATION <input type="checkbox"/> OTHER: _____</p>
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3. (Please Print) ABOUT YOU AND YOUR DEPENDENTS...

A.	(Add (C)hange (D)elete)	Name FIRST NAME LAST NAME (IF DIFFERENT)	Social Security #	Date of Birth	Sex M or F
Spouse					
1					
2					
3					
4					

B. Relationship to You: C = Child, SC = Stepchild, AC = Adopted Child*, O = Other* (*attach legal documentation)

SELF	Spouse	1	2	3	4
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4. (Please Print) ABOUT YOUR OTHER HEALTH INSURANCE AND MEDICARE...

What date did your most recent health insurance or health benefit program become effective (check box if no prior/current coverage)? / / No Coverage

What date did/will the above health insurance or health benefit program terminate? / / Name of Prior Carrier _____

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

MEDICARE INFORMATION:

Are you covered by Medicare? YES NO IF YES, Medicare No. _____

Is your spouse or dependent covered by Medicare? YES NO IF YES, Medicare No. _____

EFFECTIVE DATE: PART A: / / PART B: / / REASON FOR MEDICARE
 AGE DISABILITY END STAGE RENAL

5. (Please Print) ABOUT YOUR LIFE AND DISABILITY INSURANCE...

IF YOUR EMPLOYER OFFERS ANY OF THE FOLLOWING COVERAGES, PLEASE INDICATE IF YOU WOULD LIKE TO ENROLL IN ANY OF THESE COVERAGES AND THE AMOUNT.

BASIC LIFE	DEPENDENT LIFE	SUPPLEMENTAL LIFE	SUPPLEMENTAL AD&D	SHORT TERM DISABILITY	LONG TERM DISABILITY
<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES (AMT. \$ _____) <input type="checkbox"/> NO	<input type="checkbox"/> YES (AMT. \$ _____) <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

IF ANY YES BOX IS CHECKED ABOVE, COMPLETE THE REMAINDER OF THIS SECTION.

GROUP/DIVISION NUMBER: _____ CLASS: _____ SALARY \$ _____ HOURLY WEEKLY MONTHLY ANNUAL

FOR MLT USE ONLY
EFFECTIVE DATE: ___/___/___

	Social Security Number	Beneficiary Last Name	Beneficiary First Name	Date of Birth	Relationship	Benefit Split**
PRIMARY						
SECONDARY						%

** Unless otherwise noted, if two primary beneficiaries are named, the proceeds will be paid in equal shares to the primary beneficiaries surviving you.

6. SIGNATURES - Sign after completing and reading all applicable sections (including front of this application).

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. Signature of Spouse authorizes release of information described on the front of this application.

_____ _____ _____
 Your Signature Date Your Spouse's Signature (if applying for dependent coverage) Date

MEDICAL HISTORY QUESTIONNAIRE (for groups with up to 9 eligible employees)

7. Applicant		Social Security Number		Group Number	Date of Birth	Height	Weight		
Last									
Dependents (Full Name)		Date of Birth	Height	Weight	Dependents (Full Name)		Date of Birth	Height	Weight
Spouse									
1				4					
2				5					
3				6					

7A. Check all medical conditions, diseases listed below for which you or any of your dependents have, or have ever been diagnosed, treated or counselled: (Use number and letter to identify conditions in 7C)

<input type="checkbox"/> 1. Transplant (any organ)	<input type="checkbox"/> 19. Other Lung Disorders	<input type="checkbox"/> 36. Coronary Artery Disease
<input type="checkbox"/> 2. Connective Tissue Disease	<input type="checkbox"/> 20. Liver Disorders	<input type="checkbox"/> 37. Bypass Surgery
<input type="checkbox"/> 3. A.I.D.S./A.R.C./H.I.V.	<input type="checkbox"/> 21. Congenital Disease/Defect	<input type="checkbox"/> 38. Congestive Heart Failure
<input type="checkbox"/> 4. Arthritis, Osteo	<input type="checkbox"/> 22. Paralysis	<input type="checkbox"/> 39. Pacemaker
<input type="checkbox"/> 5. Arthritis, Rheumatoid	<input type="checkbox"/> 23. Multiple Sclerosis	<input type="checkbox"/> 40. Ischemic Heart Disease
<input type="checkbox"/> 6. Back/Spinal Disorder	<input type="checkbox"/> 24. Cerebral Palsy	<input type="checkbox"/> 41. Other Heart Disorders
<input type="checkbox"/> 7. Scoliosis	<input type="checkbox"/> 25. Epilepsy	<input type="checkbox"/> 42. High Blood Pressure
<input type="checkbox"/> 8. Spina Bifida	<input type="checkbox"/> 26. Parkinson's	<input type="checkbox"/> 43. Yes, Give Last 3 Blood Pressures & Dates A. B. C.
<input type="checkbox"/> 9. Ulcerative Colitis	<input type="checkbox"/> 27. Alzheimer's Disease	
<input type="checkbox"/> 10. Diverticulitis	<input type="checkbox"/> 28. Other Neurological Disorders	<input type="checkbox"/> 44. Alcohol or Drug Dependency
<input type="checkbox"/> 11. Crohn's Disease	<input type="checkbox"/> 29. Hemophilia	<input type="checkbox"/> 45. Attempted Suicide
<input type="checkbox"/> 12. Gastric/Peptic Ulcer	<input type="checkbox"/> 30. Kidney/Urinary Disorders	<input type="checkbox"/> 46. Anorexia/Bulimia
<input type="checkbox"/> 13. Other Bowel/Stomach Disorders	<input type="checkbox"/> 31. Tumors/Growths	<input type="checkbox"/> 47. Chronic Depression
<input type="checkbox"/> 14. Stroke (Date)	<input type="checkbox"/> 32. Juvenile Diabetes	<input type="checkbox"/> 48. Other Mental/Emotional Disorders
<input type="checkbox"/> 15. Cancer, Leukemia or Melanoma	<input type="checkbox"/> 33. Diabetes Mellitus	<input type="checkbox"/> 49. Venereal Disease
<input type="checkbox"/> 16. Emphysema	<input type="checkbox"/> 34. Yes, Give Last 3 Blood Sugars & Dates A. B. C.	<input type="checkbox"/> 50. Deafness
<input type="checkbox"/> 17. Chronic Bronchitis		<input type="checkbox"/> 51. Currently Pregnant
<input type="checkbox"/> 18. Asthma	<input type="checkbox"/> 35. Heart Attack/M.I.	If so, state expected date / /

7B. MEDICAL QUESTIONS

1) Within the past 5 years, have you or your dependents had, or been treated for, or been told that you have any other condition/disorder/disease not listed above? If yes, explain in 7C.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2) Within the past 5 years, have you or your dependents been hospitalized, operated on or been advised to have an operation which has not yet been performed? If yes, explain in 7C.	<input type="checkbox"/>	<input type="checkbox"/>
3) Have you or any DEPENDENT listed been treated on an outpatient basis: Testing, Rehabilitation, Home Health Care or Emergency Room within the last two years? If yes, explain in 7C.	<input type="checkbox"/>	<input type="checkbox"/>
4) Within the past 5 years, have you or your dependents been on Fertility Drugs, had a High Risk Pregnancy, Abnormal Pap Test, or a Venereal Disease? If yes, explain in 7C.	<input type="checkbox"/>	<input type="checkbox"/>
5) Are you or any of your dependents currently taking any prescription medications? If Yes, indicate medication, reason for taking and dosage per day in Section 7C.	<input type="checkbox"/>	<input type="checkbox"/>
6) Do any of the conditions identified above involve Worker's Compensation? If Yes, provide the Worker's Compensation Case Number: #: _____	<input type="checkbox"/>	<input type="checkbox"/>
7) Have you or your dependents ever been restricted from, or declined for coverage by any carrier? If yes, explain in 7C.	<input type="checkbox"/>	<input type="checkbox"/>

7C. EXPLANATION

Condition/ Question #	Individual (FULL NAME)	Physician's Name and Address	Treatment Dates (FROM /TO)	Diagnosis, Treatment, Prognosis, Medication, Dosage and Reason (be specific)

Attach a separate sheet in this format if more space is required.