



APPLICATION AND POLICY CHANGE

(PLEASE USE BALL POINT PEN)

ENROLLEE: <input type="checkbox"/> POLICY CHANGE		<input type="checkbox"/> NEW ENROLLEE		<input type="checkbox"/> COBRA APPLICATION			
GROUP NO.: <u>603406070</u>		LEVEL OF BENEFITS: <input type="checkbox"/> Single <input type="checkbox"/> Two Persons <input type="checkbox"/> Family <input type="checkbox"/> Medicare Supplemental		EMPLOYMENT STATUS: <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> COBRA			
EMPLOYEE CLOCK NUMBER:		EMPLOYEE DEPT. NO.:		PAYROLL LOCATION:			
CHANGES: <input type="checkbox"/> Add Dependents due to: <input type="checkbox"/> Marriage <input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Drop Dependents Due To: <input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> Other _____		<input type="checkbox"/> New Name <input type="checkbox"/> New Address <input type="checkbox"/> Change to Medicare Elig. <input type="checkbox"/> Change Coverage		<input type="checkbox"/> Other _____			
		DATE OF EVENT MO. DAY YR.		COV. OR CHANGE EFF. DATE MO. DAY YR.			
Last Name		First Name		M Initial			
Street Address		City		State Zip Phone No.			
Employee Date of Birth MO. DAY YR.		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Employee Social Security Number		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	Date Married MO. DAY YR.	
Employer Company Name			Date of Hire-Full Time MO. DAY YR.	Job Title			
Check Coverage Desired: <input type="checkbox"/> Health <input type="checkbox"/> Drug <input type="checkbox"/> Dental <input type="checkbox"/> Vision							
MEDICARE INFORMATION	Are you covered by Medicare? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, Medicare No. _____ Effective Date: _____ <input type="checkbox"/> Hemodialysis						
	Is your spouse covered by Medicare? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, Medicare No. _____ Effective Date: _____ <input type="checkbox"/> Hemodialysis						
OTHER INSURANCE INFORMATION	DO YOU OR ANY OF YOUR DEPENDENTS HAVE ANY OTHER HEALTH OR DENTAL COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> 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
	What date did your most recent health insurance program become effective (check box if no prior/current coverage)? ____/____/____ <input type="checkbox"/> No coverage						
	What date did/will this health insurance program terminate (check box if no prior/current coverage)? ____/____/____						
DEPENDENT INFORMATION	RELATIONSHIP	BIRTHDATE	SEX	LAST NAME (ONLY IF DIFFERENT)	FIRST NAME	SOC. SEC. NO.	OVER AGE DEPENDENT STATUS
	Spouse	MO. DAY YR.	<input type="checkbox"/> M <input type="checkbox"/> F				
	<input type="checkbox"/> Child <input type="checkbox"/> Adopted <input type="checkbox"/> Stepchild <input type="checkbox"/> Other'		<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Full-Time Student <input type="checkbox"/> Disabled Medicare Elig.; <input type="checkbox"/> Hemodialysis <input type="checkbox"/> Disability
	<input type="checkbox"/> Child <input type="checkbox"/> Adopted <input type="checkbox"/> Stepchild <input type="checkbox"/> Other'		<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Full-Time Student <input type="checkbox"/> Disabled Medicare Elig.; <input type="checkbox"/> Hemodialysis <input type="checkbox"/> Disability
	<input type="checkbox"/> Child <input type="checkbox"/> Adopted <input type="checkbox"/> Stepchild <input type="checkbox"/> Other'		<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Full-Time Student <input type="checkbox"/> Disabled Medicare Elig.; <input type="checkbox"/> Hemodialysis <input type="checkbox"/> Disability
	<input type="checkbox"/> Child <input type="checkbox"/> Adopted <input type="checkbox"/> Stepchild <input type="checkbox"/> Other'		<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Full-Time Student <input type="checkbox"/> Disabled Medicare Elig.; <input type="checkbox"/> Hemodialysis <input type="checkbox"/> Disability
	<input type="checkbox"/> Child <input type="checkbox"/> Adopted <input type="checkbox"/> Stepchild <input type="checkbox"/> Other'		<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Full-Time Student <input type="checkbox"/> Disabled Medicare Elig.; <input type="checkbox"/> Hemodialysis <input type="checkbox"/> Disability
	1. Legal Documentation (court decree, guardianship papers, etc.) must be attached to this application if relationship is marked other.						
SIGNATURE	I hereby apply to Medical Mutual (MM) for the coverage indicated above. I authorize my employer/organization to deduct from my pay and remit any required contribution for the cost of said coverage. I authorize any medical professional, hospital, clinic, or other medical or medically related facility, government agency, or other person to provide to MM information including copies of records concerning advice, care or treatment provided to me and/or my dependents including, without limitation, information relating to mental illness or use of drugs or alcohol. I understand that the kind of coverage for which I am making application contains coordination of benefits, workers' compensation, and subrogation provisions and acknowledge MM's right to enforce these provisions. I have read the above statements and represent that the information provided is true and complete to the best of my knowledge. I understand that the provision of any false information on this application may result in the termination of my benefits and may subject me to legal action by MM. I understand I must notify MM within 30 days of occurrence of any changes in status. I understand that if I am not actively at work on the date my coverage would otherwise become effective, my insurance will not begin until the day I return to work.						
	Applicant's Signature _____						Date: _____
WAIVER	I hereby waive coverage under the health insurance program <input type="checkbox"/> FOR MYSELF <input type="checkbox"/> FOR MYSELF AND FAMILY MEMBERS <input type="checkbox"/> FOR FAMILY MEMBERS ONLY <input type="checkbox"/> FOR ONLY THE FOLLOWING: _____						
	I understand that if I decide to enroll or add family members at a later date, I will be required to complete a medical history questionnaire and meet certain medical underwriting requirements before coverage will be offered. I further understand that if I and/or my eligible family members are accepted for enrollment at some future date, I am subject to the pre-existing condition restrictions specified in the contract.						
	Signature _____						Date: _____