APPLICATION AND POLICY CHANGE

(PLEASE USE BALL POINT PEN)

ENROLLEE: ☐ POLICY CHANGE ☐ NEW ENROLLEE ☐ COBRA APPLICATION

GROUP NO.: 603406070

LEVEL OF BENEFITS: ☐ Single ☐ Two Persons ☐ Family ☐ Medicare Supplemental

EMPLOYMENT STATUS: ☐ Active ☐ Retired ☐ COBRA

EMPLOYEE CLOCK NUMBER: **EMPLOYEE DEPT. NO.:** **PAYROLL LOCATION:**

CHANGES: ☐ Add Dependents due to:
☐ Marriage ☐ Birth ☐ Adoption
☐ Drop Dependents Due To:
☐ Divorce ☐ Death ☐ Other ____________

☐ New Name
☐ New Address
☐ Change to Medicare Elig.
☐ Change Coverage

☐ Other ____________

DATE OF EVENT — MO. — DAY — YR.

COV. OR CHANGE EFF. DATE — MO. — DAY — YR.

BASIC INFORMATION

Last Name First Name M Initial

Street Address City State Zip Phone No.

Employee Date of Birth MO. DAY YR. | Sex ☐ M ☐ F | Employee Social Security Number | Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced | Date Married MO. DAY YR.

Employer Company Name | Date of Hire-Full Time MO. DAY YR. | Job Title

Check Coverage Desired: ☐ Health ☐ Drug ☐ Dental ☐ Vision

MEDICARE INFORMATION

Are you covered by Medicare? ☐ YES ☐ NO If YES, Medicare No. ____________ Effective Date: ____________ ☐ Hemodialysis

Is your spouse covered by Medicare? ☐ YES ☐ NO If YES, Medicare No. ____________ Effective Date: ____________ ☐ Hemodialysis

OTHER INSURANCE INFORMATION

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
			/ /	☐Medical ☐Dental ☐Hospital Only ☐Vision ☐Prescription Drug	☐ Active ☐ Retired	☐ Single ☐ Family
			/ /	☐Medical ☐Dental ☐Hospital Only ☐Vision ☐Prescription Drug	☐ Active ☐ Retired	☐ Single ☐ Family

What date did your most recent health insurance program become effective (check box if no prior/current coverage)?____/____/____ ☐ 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.	☐M ☐F				
☐ Child ☐ Adopted ☐ Stepchild ☐ Other¹		☐M ☐F				☐ Full-Time Student ☐ Disabled Medicare Elig.; ☐ Hemodialysis ☐ Disability
☐ Child ☐ Adopted ☐ Stepchild ☐ Other¹		☐M ☐F				☐ Full-Time Student ☐ Disabled Medicare Elig.; ☐ Hemodialysis ☐ Disability
☐ Child ☐ Adopted ☐ Stepchild ☐ Other¹		☐M ☐F				☐ Full-Time Student ☐ Disabled Medicare Elig.; ☐ Hemodialysis ☐ Disability
☐ Child ☐ Adopted ☐ Stepchild ☐ Other¹		☐M ☐F				☐ Full-Time Student ☐ Disabled Medicare Elig.; ☐ Hemodialysis ☐ 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 ☐ FOR MYSELF ☐ FOR MYSELF AND FAMILY MEMBERS ☐ FOR FAMILY MEMBERS ONLY ☐ 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: ____________

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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