MEDICAL MUTUAL®

Large Group
Employee Application/Change Form

Section I: INSURANCE WAIVER

I understand that if I check any box in Part 1 of this waiver I am choosing not to have those persons covered under the health insurance designated.

Part 1: Waived Coverages: I do not want coverage for (Check all that apply)

Myself	☐ Medical	☐ Dental	☐ Vision	☐ Life/Disability
Spouse or Domestic Partner (if your group offers coverage to Domestic Partners)	☐ Medical	☐ Dental	☐ Vision	☐ Life/Disability
Child(ren)	☐ Medical	☐ Dental	☐ Vision	☐ Life/Disability

Please list name(s) of spouse/domestic partner and/or child(ren) for whom coverage is being waived:

_____

Part 2: Reason for waiving coverage: (Check appropriate waiver type)

☐ Covered by spouse/domestic partner or parent's employer coverage

Name of Insurer: _____

☐ Medicare ☐ TRICARE ☐ VA coverage ☐ Medicaid

☐ Individual – My policy was obtained through an exchange **and** I was approved for a subsidy

Name of Insurer: _____

☐ Enrolled in another carrier's group plan offered by this employer

Name of Insurer: _____

☐ Enrolled in another employer's group plan as an employee or retiree

Name of Insurer: _____

☐ Other:_____ ☐ No coverage

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance coverage or group health plan coverage, you may be able to enroll yourself or your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward you or your dependents other coverage). However, you must request enrollment within 30 days after you or your dependent's other coverage ends (or after the employer stops contributing toward other coverage). If you or your dependent either becomes eligible for premium assistance or lose eligibility for coverage under the States Children's Health Insurance Program (SCHIP), you will be able to enroll in this plan. However you must request enrollment within 60 days after such event. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

I have read and understood the above terms:

Current Employer_____ MMO Group Number _____

Print Employee Name _____

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. 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.

Please Note: Products marketed by Medical Mutual may be underwritten by one of its subsidiaries, such as Medical Health Insuring Corporation of Ohio or MedMutual Life Insurance Company.

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

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Section II: ACTION REQUIRED

☐ New Application ☐ COBRA/Continuation ☐ Policy Change ☐ Change to Medicare Eligibility

Qualifying event date: _____

Action: (check type of change)

☐ Add dependent to the policy due to: (list dependents in section III) ☐ Birth ☐ Adoption

☐ Delete dependent from policy due to: (list dependents in section III) ☐ Divorce ☐ Death ☐ Other_____

☐ Add spouse due to marriage (list Spouse in section III)

Date married: _____

☐ Name change (list new name in section III)

Former name: _____

☐ Address change (enter new address in Section III)

☐ Cancel coverage

☐ Other (description) _____

Section III: APPLICANT INFORMATION

Last Name	First Name	MI

Permanent Residence	City	E-mail Address

County	State	Zip Code	Best Contact # ( )	Alternate # ( )

Employment Status	Marital Status
☐ Active, **Full Time Date of (Re)Hire:** _____ ☐ Retired ☐ COBRA, Expiration Date: _____	☐ Single ☐ Married

Employee Clock Number:	Employee Dept. Number:	Payroll Location:

Relationship	First Name, MI (and last name, if different)	Social Security Number[2]	Birth Date	Gender	Tobacco User Tobacco User definition –the legal use (other than religious or ceremonial) of any tobacco product on average four or more times per week within no longer than the last six months.
Self				☐ M ☐ F	☐ **Y** ☐ **N**
Spouse				☐ M ☐ F	☐ **Y** ☐ **N**
Domestic Partner[1]				☐ M ☐ F	☐ **Y** ☐ **N**
Dependent Child				☐ M ☐ F	☐ **Y** ☐ **N**
Dependent Child				☐ M ☐ F	☐ **Y** ☐ **N**
Dependent Child				☐ M ☐ F	☐ **Y** ☐ **N**

[1]Refer to Section VII, Number 10, Terms and Conditions, for domestic partner eligibility requirements, if offered by your group.
[2]Providing Social Security Number is required by federal law.

PRIMARY CARE PHYSICIAN INFORMATION (HMO Plans Only)

Physician Name	Physician Phone Number ( ) –	Physician's NPI Number

Physician Address		

City	State	ZIP Code

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

MEDICAL MUTUAL®

Section IV: 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
				☐ Age ☐ End Stage Renal ☐ Disability, Indicate Reason: _____
				☐ Age ☐ End Stage Renal ☐ Disability, Indicate Reason: _____

Important Notice for Medicare Eligible Individuals: If you are entitled to Medicare and Medicare is your primary coverage, you should enroll in and maintain that coverage, because when Medical Mutual is the secondary payer to Medicare Part B, Medical Mutual's plan will coordinate benefits as if you were covered under Part B, even if you are not. This can result in you being responsible for costs that would have been paid by Medicare. Your broker can assist you with any questions.

(If you are entitled to Medicare because you are 65 and over and your employer employs fewer than 20 employees; or if you are entitled to Medicare due to disability and your employer employs fewer than 100 employees, Medicare will be the primary payer, that is, Medicare must pay benefits before the group health plan pays benefits.)

Continuing Coverage (other than Medicare) Are you or any dependent keeping other or dental 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
				☐ Medical ☐ Dental ☐ Hospital Only ☐ Vision ☐ Prescription Drug	☐ Active ☐ Retired	☐ Single ☐ Family

Section V: 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:_____

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

MEDICAL MUTUAL®

Section VI: MEDICAL, DENTAL AND VISION PRODUCTS

Plan selected (if more than one offered):_____

Section VII: LIFE AND DISABILITY PRODUCTS

A. COVERAGE SELECTION

Your group insurance provided by MedMutual 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.

Employer Paid Plans*

Elect	Waive	Coverage Type
☐	☐	Basic Life and AD&D
☐	☐	Dependent Life
☐	☐	Short-Term Disability
☐	☐	Long-Term Disability

Class and Salary Information

Life Class:

Occupation/Job Title:

Current Earnings: $

☐ Hour ☐ Month ☐ Week ☐ Year

*If employer pays 100% of premium, employee may not waive coverage

Employee Paid Plans**

Elect	Waive	Coverage Type	Amount
☐	☐	**Supplemental Life**	$_____
☐	☐	**Supplemental AD&D**	$_____
☐	☐	**Dependent Life**	$_____

B. VOLUNTARY SHORT-TERM DISABILITY PRE-EXISTING CONDITION NOTICE

MedMutual Life will not cover a disability which begins in the first 12-months after your effective date of coverage that is caused by, contributed to by, or results from a Pre-existing condition.

A Pre-existing condition is a sickness or injury for which you, within 12 months of your effective date of coverage:

1. Received medical treatment, consultation, care of service, including diagnostic measures, or
2. had taken prescribed drugs or medicines.

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:				

Continued on page 5

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

MEDICAL MUTUAL®

Section VII: LIFE AND DISABILITY PRODUCTS (continued)

D. VOLUNTARY FIXED INDEMNITY AND ACCIDENT-ONLY PLANS (MEDMUTUAL EXTEND) (51-99 Only)

- ☐ Premium
- ☐ Preferred
- ☐ Select
- ☐ Critical Illness
- ☐ Accident

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

MEDICAL MUTUAL®

Section VIII: TERMS AND CONDITIONS

I hereby apply to the carrier(s) offering the coverage indicated on this Application. Your insurance is being offered through Medical Mutual of Ohio and/or one of its wholly owned subsidiaries, Medical Health Insuring Corporation of Ohio, or MedMutual Life Insurance Company, collectively referred to as "Medical Mutual."

1. I authorize: (1) payroll deduction(s) and remittance of any required contribution for coverage to Medical Mutual and/or any affiliates or divisions of Medical Mutual; (2) release of information, without limitation, from any medical/medically related facility, prior health insurance carrier, the Medical Information Bureau, Inc. (MIB), prescription history database supplier, pharmacy benefit manager, government agency or person to Medical Mutual and/or any affiliates or division of Medical Mutual: (a) to evaluate this Application; (b) to adjudicate claims submitted on behalf of me or my dependents; (c) for utilization review programs to monitor health services or quality improvement activities and/or; (d) for credentialing purposes. I authorize Medical Mutual to provide a photocopy of this release to any physician or medical institution to obtain records for the purposes stated above. This authorization will be valid for a period of two and one-half years for the purpose of collecting information regarding this Application. I authorize Medical Mutual or its reinsurers to make a brief report of my personal health information to MIB.
2. By signing below, I represent and warrant as follows: (a) I have thoroughly read and understand this Health and Life Application and the questions asked herein; (b) I am solely and exclusively responsible for the truth, accuracy and completeness of all of the answers contained in this Application; (c) I have answered each and every question set forth in this Application; (d) all of my answers to each of the questions are accurate, complete and true and (e) I did not sign a blank or partially completed Application. I agree that Medical Mutual, in it's sole discretion, may rescind my policy on the basis of any material misrepresentation or fraudulent response to any question in this Application. I further agree that if a policy is issued, it will be issued by Medical Mutual in full reliance and in consideration of the information, answers and statements contained herein.
3. I agree that: (a) to be eligible for coverage, I must be an active full-time employee as defined by the policy(ies); (b) to be eligible for life, disability income, fixed indemnity and/or accident-only insurance, I must be actively at work as defined in the group policy. If I am not actively at work on the date my life, disability, fixed indemnity and/or accident-only coverage would become effective, such coverage will begin on the day I return to work; and (c) if coverage is issued, it will be based on full reliance on the information contained in this Application.
4. I have read the sales materials and understand the plan benefits, exclusions, and limitations as outlined therein. I acknowledge that the managed care features of this health insurance policy (such as the preferred provider organization network) have been explained to my satisfaction. The applicable certificate or evidence of coverage will determine the rights and responsibilities of covered persons and will govern in the event they conflict with any benefit comparison summary or other description of the plan.
5. No issuance, waiver, modification or change of policy or any of Medical Mutual rules or amendments shall be binding upon Medical Mutual unless it is in writing and signed by an authorized officer of Medical Mutual, as applicable.
6. Other than for fixed indemnity and accident-only plans, a permanent ID card will be issued following the final review and acceptance of this Application.
7. I understand and agree that no agent or broker who may be assisting in the completion of this Application has any authority: (a) to waive any answer or any portion of any answer to any question on this Application or any information Medical Mutual requests; (b) to advise me that I am not obligated to disclose any condition of which I am aware concerning my health or the health of any dependent included on the Application; (c) to make any representation concerning benefits that are inconsistent with, or different from, any written information provided by Medical Mutual; or (d) to bind Medical Mutual in any way by making any statement, promise or representation that is not set out in writing in this Application or regarding eligibility, benefits or issuance of a policy; (e) to answer any questions in, or insert any information on, this Application on my behalf; or (f) to approve coverage.

Continued on page 8

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

MEDICAL MUTUAL®

Section VIII: TERMS AND CONDITIONS (continued)

8. My dependents and I understand and agree that any information obtained will not be released by Medical Mutual to any person or organization except to reinsuring companies, the MIB, or other persons or organizations performing health care operations, payment related, or business or legal services in connection with any application, claim, or as may be otherwise lawfully required, or as we may further authorize. If a Consumer Reporting Agency is used, I (we) may request to be interviewed in connection with the preparation of the report. Once personal and health (including medical, dental, and pharmacy) information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal and state privacy requirements. A copy of this authorization request is available to me or my legal representative upon written request. A photographic copy of this authorization shall be as valid as the original. This authorization shall be valid for a period of two and one-half years. I have the right to revoke this authorization at any time. To revoke this authorization, I must do so in writing and send my written revocation to Medical Mutual's Privacy Office. The revocation will not apply to information that has already been released in response to this authorization. The revocation may adversely affect my application, a claim or a pending insurance action. The revocation will become effective after it is received by Medical Mutual Privacy Office. Your refusal to authorize the release of this information may impact your ability to enroll in Medical Mutual's plan if Medical Mutual needs this information to determine your eligibility for coverage.

9. I understand and acknowledge that this authorization extends to all medical records, including records which may contain information regarding treatment for physical and mental illness, alcohol/drug abuse and/or HIV – AIDS test results or diagnosis. I expressly consent to the release of such information.

10. If I am applying for coverage for my domestic partner (if offered by your group), I represent and warrant that I and my domestic partner: 1) cohabit and reside together in the same residence and have done so for at least six months and intend to do so indefinitely; 2) are engaged in an exclusive and committed relationship and are financially interdependent; 3) are both at least 18 years of age and are each other's sole domestic partner; 4) are not married or separated from anyone else; 5) have not had another domestic partner within six months of establishing the current domestic partnership; 6) are not related by blood; and 7) are not in this relationship solely for the purpose of obtaining insurance benefits.

I am signing this Application on my own behalf and on behalf of all listed dependents. An unaltered copy of this authorization is as valid as the original.

_____ _____

Applicant's or Guardian's Signature Date

WARNING: Any person who, with intent to defraud or knowing that he is facilitating 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).

Multi-Language Interpreter Services & Nondiscrimination Notice

This document notifies individuals of how to seek assistance if they speak a language other than English.

Spanish

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-382-5729 (TTY: 711).

Chinese

注意:如果您使用繁體中文,您可以免費獲得語言援助服務。請致電 1-800-382-5729 (TTY: 711)。

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-382-5729 (TTY: 711).

Arabic

ملحوظة:إذاكنت تتحدث اذكر اللغة،فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-382-5729 رقم هاتف الصم والبكم 711).

Pennsylvania Dutch

Wann du Deitsch schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-382-5729 (TTY: 711).

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-382-5729 (телетайп: 711).

French

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-382-5729 (ATS: 711).

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-382-5729 (TTY: 711).

Navajo

Díí baa akó nínízin: Díí saad bee yáníłti' go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-800-382-5729 (TTY: 711).

Oromo

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-382-5729 (TTY: 711).

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-382-5729 (TTY: 711)번으로 전화해 주십시오.

Italian

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-382-5729 (TTY: 711).

Japanese

注意事項:日本語を話される場合、無料の言語支援をご利用いただけます。1-800-382-5729 (TTY: 711) まで、お電話にてご連絡ください。

Dutch

AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-800-382-5729 (TTY: 711).

Ukrainian

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-382-5729 (телетайп: 711).

Romanian

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-382-5729 (TTY: 711).

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-382-5729 (TTY: 711).

Please Note: Products marketed by Medical Mutual may be underwritten by one of its subsidiaries, such as Medical Health Insuring Corporation of Ohio or MedMutual Life Insurance Company.

Order Number: Z8188-MCA R4/19
Dept of Ins. Filing Number: Z8188-MCA R9/16

QUESTIONS ABOUT YOUR BENEFITS OR OTHER INQUIRIES ABOUT YOUR HEALTH INSURANCE SHOULD BE DIRECTED TO MEDICAL MUTUAL'S CUSTOMER CARE DEPARTMENT AT 1-800-382-5729.

Nondiscrimination Notice

Medical Mutual of Ohio complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex in its operation of health programs and activities. Medical Mutual does not exclude people or treat them differently because of race, color, national origin, age, disability or sex in its operation of health programs and activities.

- Medical Mutual provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, etc.).
- Medical Mutual provides free language services to people whose primary language is not English, such as qualifi ed interpreters and information written in other languages.

If you need these services or if you believe Medical Mutual failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, with respect to your health care benefits or services, you can submit a written complaint to the person listed below. Please include as much detail as possible in your written complaint to allow us to effectively research and respond.

Civil Rights Coordinator
Medical Mutual of Ohio
2060 East Ninth Street
Cleveland, OH 44115-1355
MZ: 01-10-1900

Email: CivilRightsCoordinator@MedMutual.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights.

- Electronically through the Office for Civil Rights Complaint Portal available at:
  ocrportal.hhs.gov/ocr/portal/lobby.jsf
- By mail at:
  U.S. Department of Health and Human Services
  200 Independence Avenue, SW Room 509F
  HHH Building
  Washington, DC 20201-0004
- By phone at:
  1-800-368-1019 (TDD: 1-800-537-7697)
- Complaint forms are available at:
  hhs.gov/ocr/office/file/index.html

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