

**EMPLOYEE  
APPLICATION and CHANGE FORM**  
for individuals in  
Groups with up to 19 eligible employees



**INSTRUCTIONS**

- **PRINT CLEARLY USING A BLUE OR BLACK PEN (NO HIGHLIGHTERS).**
- **NEW HIRES, LATE ENTRANTS AND DEPENDENT ADDITIONS MUST COMPLETE THE APPLICATION INCLUDING GROUP NUMBER AND MEDICAL HISTORY QUESTIONNAIRE.**
- **CHANGES TO AN EXISTING POLICY, COMPLETE ONLY AREA THAT IS CHANGING E.G.: MARRIAGE, DIVORCE, DROPPING DEPENDENTS...**
- **IF ENROLLING A DEPENDENT/STUDENT, A STUDENT CERTIFICATION FORM MUST BE INCLUDED WITH THE APPLICATION.**
- **IF YOU DO NOT WANT ANY COVERAGE OR IF YOU REJECT SOME OF THE COVERAGE OPTIONS BUT ACCEPT OTHERS, COMPLETE THE WAIVER AREA BELOW.**

**WAIVER**

**A. Waived Coverages:** I do NOT want...(Check all that apply)

- HEALTH through Medical Mutual of Ohio® (Medical Mutual)
- HEALTH through Medical Mutual for the following dependents only: (Remember to complete the rest of this application)
- 1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_ 4) \_\_\_\_\_ 5) \_\_\_\_\_
- LIFE/DISABILITY through Fort Dearborn Life Insurance Company® (FDL)

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

- Coverage through my Spouse's Employer: \_\_\_\_\_  
Spouse's Company Name
- No coverage
- Other coverage: \_\_\_\_\_

**C. Authorization:** The terms of this waiver are explained below. I have read and understand these terms.

Company Name: \_\_\_\_\_

Print Employee Name: \_\_\_\_\_ Employee Social Security #: \_\_\_\_\_

Print Spouse Name: \_\_\_\_\_ Spouse Social Security #: \_\_\_\_\_

Signature of Employee: \_\_\_\_\_ Date: \_\_\_\_\_

**THE EXPLANATION OF WAIVER**

I understand that if I check any box in Question A of the Waiver above or check NO for any coverage offered in Section 5, that I am choosing not to have those persons covered under the health, life or disability 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 health 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. 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, provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.**

# HEALTH AND LIFE APPLICATION / POLICY CHANGE

GROUP # \_\_\_\_\_ SECTION \_\_\_\_\_

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

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

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

|  |   |
|--|---|
| <p style="text-align: center;"><b>A) NEW POLICY APPLICATION</b></p> <p>1. Type of Coverage:<br/> <b>PRIMARY COVERAGE:</b> (check only one)<br/> <input type="checkbox"/> SuperMed Classic<br/> <input type="checkbox"/> SuperMed Plus<br/> <input type="checkbox"/> SuperMed Share<br/> <input type="checkbox"/> SuperMed Choice Options _____<br/> <small>Choice Options Key at bottom of page 4</small></p> <p><b>ADDITIONAL COVERAGE(S):</b> (check all that apply)<br/> <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life</p> <p>2. Who Do You Want Covered?<br/> <input type="checkbox"/> You Only <input type="checkbox"/> You and One Other Person <input type="checkbox"/> You and Your Family<br/>                 Medicare Supplement For: <input type="checkbox"/> You <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent</p> | <p style="text-align: center;"><b>B) CHANGE TO AN EXISTING POLICY</b></p> <p>1. Group # _____ Section # _____</p> <p>2. Date of Change: ____/____/____</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"/> MARRIED: DATE MARRIED _____</p> <p><input type="checkbox"/> NAME CHANGE: FORMER NAME: _____</p> <p><input type="checkbox"/> OTHER: _____</p> |
|--|---|

## 3. (Please Print) ABOUT YOU AND YOUR DEPENDENTS...

| A.     | (Add<br>(C)hange<br>(D)elete | First Name | Last Name | Social Security # | Date of Birth | Sex<br>M or F | Height | Weight | Relationship to you** |
|--------|------------------------------|------------|-----------|-------------------|---------------|---------------|--------|--------|-----------------------|
| SELF   |                              |            |           | - -               | - -           |               |        |        |                       |
| Spouse |                              |            |           | - -               | - -           |               |        |        |                       |
| 1      |                              |            |           | - -               | - -           |               |        |        |                       |
| 2      |                              |            |           | - -               | - -           |               |        |        |                       |
| 3      |                              |            |           | - -               | - -           |               |        |        |                       |
| 4      |                              |            |           | - -               | - -           |               |        |        |                       |

\*\*Relationship to You: C = child, SC = stepchild, AC = adopted Child\*, O = other\* (\*attach legal documentation)

## 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<br><input type="checkbox"/> Hospital Only <input type="checkbox"/> Vision<br><input type="checkbox"/> Prescription Drug | <input type="checkbox"/> Active<br><input type="checkbox"/> Retired | <input type="checkbox"/> Single<br><input type="checkbox"/> Family |
|                       |   |               | / /            | <input type="checkbox"/> Medical <input type="checkbox"/> Dental<br><input type="checkbox"/> Hospital Only <input type="checkbox"/> Vision<br><input type="checkbox"/> Prescription Drug | <input type="checkbox"/> Active<br><input type="checkbox"/> Retired | <input type="checkbox"/> Single<br><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: / /  
 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 FDL 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

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 HEALTH QUESTIONNAIRE

**7.**

## MEDICAL CONDITIONS

Have you, your spouse, or any listed dependent been treated for, diagnosed as having been recommended for future surgery, diagnostic testing or medical treatment or thought you should seek medical advice for any of the following conditions?

**7 IF YES, PLEASE CHECK THE CONDITION AND EXPLAIN IN SECTION 7b**

|   |  |   |   |
|---|--|---|---|
| <p><b>Cancer</b></p> <input type="checkbox"/> Type _____<br><input type="checkbox"/> Leukemia<br><input type="checkbox"/> Lymphoma<br><input type="checkbox"/> Chemotherapy<br><input type="checkbox"/> Radiation   | <p><b>HEART/CIRCULATORY</b></p> <input type="checkbox"/> Aneurysm (type _____)<br><input type="checkbox"/> CAD/Angina<br><input type="checkbox"/> Angioplasty (date _____)<br><input type="checkbox"/> Bypass Surgery (date _____)<br><input type="checkbox"/> Congestive Heart Failure<br><input type="checkbox"/> Heart Attack (date _____)<br><input type="checkbox"/> Pacemaker/ICD Implant<br><input type="checkbox"/> Stroke (date _____)<br><input type="checkbox"/> Blood Clot<br><input type="checkbox"/> Irregular Heart Beat<br><input type="checkbox"/> Peripheral Vascular<br><input type="checkbox"/> Anemia (type _____)<br><input type="checkbox"/> Other Blood disorder (type _____)<br><input type="checkbox"/> Hypertension<br><input type="checkbox"/> Blood Pressure Readings 1) _____ 2) _____ 3) _____<br><input type="checkbox"/> High Cholesterol<br><input type="checkbox"/> Other _____ | <p><b>ENDOCRINE</b></p> <input type="checkbox"/> Diabetes (type 1-insulin)<br><input type="checkbox"/> Diabetes (type 2-oral)<br><input type="checkbox"/> Diabetes diet / exercise only<br><input type="checkbox"/> Thyroid disorder<br><input type="checkbox"/> Other _____  | <p><b>URINARY/BOWEL/REPRODUCTIVE</b></p> <input type="checkbox"/> Abnormal Pap (date _____)<br><input type="checkbox"/> Colon Polyps<br><input type="checkbox"/> Crohn's<br><input type="checkbox"/> Diverticulitis<br><input type="checkbox"/> Enlarged Prostate<br><input type="checkbox"/> Gastric Reflux<br><input type="checkbox"/> Kidney Stones<br><input type="checkbox"/> Ulcer<br><input type="checkbox"/> Ulcerative Colitis<br><input type="checkbox"/> Infertility<br><input type="checkbox"/> Other _____ |
| <p><b>LUNG/RESPIRATORY</b></p> <input type="checkbox"/> Allergies - shots? Yes <input type="checkbox"/> No <input type="checkbox"/><br><input type="checkbox"/> Asthma<br><input type="checkbox"/> Cystic Fibrosis<br><input type="checkbox"/> Emphysema-oxygen? Yes <input type="checkbox"/> No <input type="checkbox"/><br><input type="checkbox"/> Other _____ | <p><b>MUSCULAR/SKELETAL</b></p> <input type="checkbox"/> Degenerative Disc Disease<br><input type="checkbox"/> Fibromyalgia<br><input type="checkbox"/> Herniated disc<br><input type="checkbox"/> Osteo Arthritis<br><input type="checkbox"/> Rheumatoid Arthritis<br><input type="checkbox"/> Other _____  | <p><b>NEUROLOGICAL</b></p> <input type="checkbox"/> Cerebral Palsy<br><input type="checkbox"/> Epilepsy - Grand Mal <input type="checkbox"/> Petit Mal <input type="checkbox"/><br><input type="checkbox"/> Multiple Sclerosis<br><input type="checkbox"/> Parkinson's Disease<br><input type="checkbox"/> Other _____  | <p><b>OTHER</b></p> <input type="checkbox"/> Transplant (type _____)<br><input type="checkbox"/> HIV<br><input type="checkbox"/> Hemophilia<br><input type="checkbox"/> Connective Tissue (type _____)<br><input type="checkbox"/> Hepatitis- (type _____)<br><input type="checkbox"/> Other _____  |
|   |  | <p><b>PSYCHOLOGICAL</b></p> <input type="checkbox"/> Depression<br><input type="checkbox"/> Manic Depression/Bipolar<br><input type="checkbox"/> Schizophrenia<br><input type="checkbox"/> Hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/> (date _____)<br><input type="checkbox"/> Suicide attempt - (date _____)<br><input type="checkbox"/> Other _____ |   |

### 7a. MEDICAL QUESTIONS (Explain all yes answers in Section 7b)

- |  |                          |                          |
|--|--------------------------|--------------------------|
| 1) Have you or your dependents been treated for or told that you have any other condition/disorder/disease not listed above?           | YES                      | NO                       |
| 2) Have you or your dependents been hospitalized, operated on or been advised to have an operation which has not yet been performed?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) Are you an expectant parent or any of your dependents currently pregnant? If so, what is the due date? _____                        | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) Are you or any of your dependents currently taking any medications? If "yes" indicate medication, reason for taking in section 7B   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5) Do any of the conditions identified involve Workmans' Compensation? If "yes" provide the Workers' Compensation Case Number: # _____ | <input type="checkbox"/> | <input type="checkbox"/> |

### 7b. EXPLANATION

| Condition | Individual's Name | Physician's Name/Address | Treatment Date (From-To) | Diagnosis/Treatment/Prognosis/Medication/Dosage/Reason (be specific) |
|-----------|-------------------|--------------------------|--------------------------|--|
|           |                   |                          |                          |  |
|           |                   |                          |                          |  |
|           |                   |                          |                          |  |
|           |                   |                          |                          |  |
|           |                   |                          |                          |  |
|           |                   |                          |                          |  |
|           |                   |                          |                          |  |
|           |                   |                          |                          |  |
|           |                   |                          |                          |  |
|           |                   |                          |                          |  |

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

**I hereby apply to Medical Mutual and/or to FDL for the coverage indicated on this application.**

- \* I authorize: (1) payroll deduction(s) and remittance of any required contribution for coverage to Medical Mutual, FDL and/or any affiliates or divisions of Medical Mutual; (2) release of information, without limitation, from any medical/medically-related facility, government agency or person: (a) to evaluate this application for up to 30 months from the date of this application; (b) to adjudicate claims submitted on behalf of me or my dependents as long as I am covered under this policy; (c) for utilization review programs to monitor health services or quality improvement activities; (d) for credentialing purposes. I authorize the applicable carrier to provide a photocopy of this release to any physician or medical institution to obtain records for the purposes stated above.
- \* I understand: (1) any untrue or incomplete information, statements or answers on this application (whether intentional or not), can result in denial of a claim or rescission of coverage and may subject me to legal action by Medical Mutual or FDL; (2) to be eligible for health coverage, I must be an active full-time employee, as defined by my employer; (3) I must be actively at work, as defined in the group's insurance policy to obtain life and/or disability coverage. If I am not actively at work on the date my life and/or disability coverage would become effective, my coverage will not begin until the day I return to work; (4) if coverage is issued, it will be based on full reliance on the information contained in this application.
- \* I understand and agree that no agent or broker has the authority: (1) to bind Medical Mutual and/or FDL by making promises regarding eligibility, benefits, or the issuance of a policy; (2) to waive any answer or any portion of any answer to any question on this application or any information Medical Mutual and/or FDL requests; (3) approve coverage; (4) make or alter any contract on behalf of Medical Mutual and/or FDL; or (5) waive or alter any of Medical Mutual's and/or FDL's other rights or requirements. All contract terms must be in writing and signed or accepted in writing by an authorized representative of Medical Mutual and/or FDL to be binding on Medical Mutual and/or FDL.
- \* I understand that, if my personal health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
- \* I understand that I have a right to revoke this authorization at any time. My revocation must be in writing. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my personal health information have acted in reliance upon this authorization.
- \* 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.

**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)

**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 can 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 \_\_\_\_\_