| 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:** _____<br>☐ Retired<br>☐ COBRA, Expiration Date: _____ | ☐ Single<br>☐ 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<br>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) |

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## 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<br>☐ Disability, Indicate Reason:<br>_____ |
| | | | | ☐ Age ☐ End Stage Renal<br>☐ Disability, Indicate Reason:<br>_____ |

**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<br>☐ Dental<br>☐ Hospital Only<br>☐ Vision<br>☐ Prescription Drug | ☐ Active<br>☐ Retired | ☐ Single<br>☐ 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) |

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**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).