MEDICAL MUTUAL OF OHIO®
Your healthcare partner since 1934

Employer/Group Enrollment Application & Change Form

MMO 1-99 Eligible Employees

CONSUMERS LIFE INSURANCE COMPANY®
A MEDICAL MUTUAL OF OHIO® Company

Z5360 R10/07

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Employer Group Enrollment Application/Change Form

MMO 1-99 Eligible Employees

☐ initial enrollment ☐ change

1. Group/Company Information

Business Name				
Has this business ever been known by another name? ☐ Yes ☐ No If yes, what name(s)?			MMO Membership # (if applicable)	
Business Address (No P.O. Boxes)			Billing Address	
City	County	State	Zip Code	Business Phone Number
Chief Executive Officer	Billing Contact			Business Fax Number
Business E-Mail	Number of years in business (If less than one year specify the date the business started.)			
Type of Business (be specific)	SIC Code			Employer/Federal Tax ID #
Do you have any affiliations with other companies or unions (include parent, subsidiary, joint venture, etc...)? ☐ Yes ☐ No If yes, please describe.				Dun and Bradstreet #
If yes, do any of these affiliates qualify as a single employer under subsection (b), (c), (m), or (o) of the Internal Revenue Code Section 414? If yes, please give the legal names, federal tax ID# and number of employees.				Has group ever applied with MMO? ☐ Yes ☐ No If so, when?
				Is the employer contribution at least 25% of each contract? ☐ Yes ☐ No

2. Enrollment Criteria

Eligible Employee Definition: What is the minimum # of hours to be worked per week for employees to be considered eligible for insurance benefits*_____

Waive probationary period for initial enrollment? ☐ Yes ☐ No

Probation Period for New Hire Benefits

☐ Date of Hire ☐ First of month following Date of Hire ☐ 30 days following Date of Hire
☐ First of month following 30 days ☐ 60 days following Date of Hire ☐ First of month following 60 days
☐ 90 days following Date of Hire

Probation Period for Rehire ☐ Same as above ☐ Other _____

*Minimum must be within 20 – 25 hours per week, for full time eligibility for groups with 50 or fewer eligible employees.

**Including owners, officers and partners who receive compensation from the company, reported on a tax other than a 1099.

Participation	Active**	COBRA	Retired**
Total number of current employees (part time & full time)			
Total number of eligible employees			
Number of eligible employees applying for coverage			
Total number of ineligible employees			

3. Health and Prescription Plans

Group Size						Proposed Effective Date
1+	SuperMed Plus w/Rx (except as noted)	☐ 1000/3000 ☐ 2000/6000 ☐ 3000/9000	☐ 15100 ☐ 1590 ☐ 1580	☐ 2080-250 ☐ 2080-500 ☐ 2080-750 ☐ 2080-1000	☐ 2000 w/Maj Med Drug ☐ 2500 w/Maj Med Drug ☐ 5000 w/Maj Med Drug ☐ 5000	
1+	High Deductible Health Plan Options: (HSA Compatable Plans)	☐ SMP 2500 ☐ SMP 3000 ☐ SMP 4000 ☐ SMP 5000				
1+	SuperMed Classic w/Rx (Hospital Panel)	☐ 250	☐ 500	☐ 750	☐ 1000	
	Prescription Drug Options	☐ Option 1	☐ Option 2	☐ Option 3	☐ Option 4	
51+		☐ Other (NBR Required)_____				
1+		☐ Medifil	☐ Medifil without Drug		☐ Medicare Carveout	

4. Dental Plans

1+	Dental Without Orthodontia	☐ SuperDental 180	☐ SuperDental 186	☐ Traditional
25+	Dental With Orthodontia	☐ SuperDental 180	☐ SuperDental 186	☐ Traditional

5. Vision Plans

1+		☐ SuperMed Vision Plan E

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6. Life and Disability Plans

Contributions:				Waiting Period (if different from medical)	Proposed Effective Date
	Life/AD&D	☐ 100%	☐ Other ____%		
	STD	☐ 100%	☐ Other ____%	☐ None	
	Dependent Life	☐ 100%	☐ Other ____%	☐ First of the month following completion of ____ days	
	Other ____	☐ 100%	☐ Other ____%	☐ Other ____	

Schedule of Benefits

A. Class Definitions (if more than one class, definitions must be specific)

Class 1 ____

Class 2 ____

Class 3 ____

Class 4 ____

B. Selection of Coverages(s) (check all that apply and fill in all applicable blanks)

	☐ Basic Life Insurance	☐ Basic AD&D	☐ Supplemental Life	☐ Supplemental AD&D	☐ Short-Term Disability
Class	Amount of Insurance	Principal Sum	Amount of Insurance	Principal Sum	Weekly Maximum
1					
2					
3					
4					

1. Weekly STD benefit is subject to a maximum of ____% of employee's Basic Weekly Wage.
2. STD Benefits Payable: ____ day of Accident; ____ day of Sickness for a maximum benefit period of ____ weeks.
3. 1st day Hospital? ☐ Yes ☐ No
4. STD Benefits payable for non-occupational disabilities only.
5. All benefits terminate at retirement unless otherwise noted in class definition section.
6. STD Benefits not available for employees working in CA, HI, NJ, NY, PR or RI.
7. Life or AD&D benefits include 24 hour coverage.
8. If Life or AD&D benefits are based upon a multiple of salary, benefit amounts should be rounded to:

   ☐ the next higher multiple of $1,000 ☐ the nearest multiple of $1,000 ☐ other ____

9. Basic Life and AD&D benefits reduce by:

   ☐ 35% at age 65; and further reduces to 50% of the face amount at age 70

   ☐ 35% at age 65; and further reduces 35% every 5 years thereafter

   ☐ ____% at age 65; and further reduces ____% of the face amount at age ____ ; and further reduces to ____% of the face amount at age ____.

10. Supplemental Life and AD&D benefits reduce by:

   ☐ 35% at age 65; and further reduces to 50% of the face amount at age 70

   ☐ 35% at age 65; and further reduces 35% every 5 years thereafter

   ☐ ____% at age 65; and further reduces ____% of the face amount at age ____ ; and further reduces to ____% of the face amount at age ____.

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6. Life and Disability Plans (continued)

Dependent Life Insurance

Spouse: $ _____

Child(ren): $ _____ Live birth but less than 15 days

$ _____ Age 15 days but less than 6 months

$ _____ Age 6 months but less than 19 year

$ _____ Age 19 years but less than ____, if full time student(s) and dependent upon the insured for support

C. Non-Medical Maximum (amounts in excess of the amount stated are subject to satisfactory evidence of insurability)

Life Basic: $ _____ Supplemental: $ _____ Combined Basic and Supplemental: $ _____

STD: $ _____ Other: $ _____

D. General Conditions

It is understood and agreed that this application shall be made part of the Policy for which application is made. It is further understood:

1. Being **Actively at Work** is a requirement for coverage. If an employee is **not Actively at Work** on the day his coverage would otherwise be effective, the effective date of his coverage will be the date of his return to **Active Work**. If an employee does not return to **Active Work**, he will not be covered.

   The terms "Actively at Work" and "Active Work" mean that an employee is performing the Material and Substantial Duties of his occupation; is working the number of hours specified in Part 6A, Schedule of Benefits; and satisfies any other conditions required by the applicable group Policy.
2. This insurance is subject to the approval of Consumers Life Insurance Company, and nothing contained herein shall be binding upon Consumers Life until this application is approved and accepted at Consumers Life's home office.
3. No waiver or change will bind Consumers Life unless signed by an Executive Officer of Consumers Life.
4. As of the proposed effective date are any of your employees **not Actively at Work** (as defined above) **and therefore not eligible for coverage?**

   ☐ Yes ☐ No If yes, please provide the following information: (attached a signed dated sheet if more space is needed)

Name _____ Sex _____ Date of Birth _____ Date Last Worked _____

Reason not Actively at Work: ☐ Disability ☐ Family Leave ☐ Other

Name _____ Sex _____ Date of Birth _____ Date Last Worked _____

Reason not Actively at Work: ☐ Disability ☐ Family Leave ☐ Other

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7. Current and Prior Carrier History

List all carriers used for all product lines of insurance offered to the employees for the past 5 years. If there are no carriers, indicate NONE. (list current carrier first)

Carrier Name	Continuing Coverage	Benefits*	Dates From	Dates To	Current Rates** Employee	Current Rates** & Spouse	Current Rates** & Child	Current Rates** Family	Renewal Rates** Employee	Renewal Rates** & Spouse	Renewal Rates** & Child	Renewal Rates** Family
	☐											
	☐											
	☐											

*Examples: Traditional, Comprehensive Major Medical, Self Insured, etc... **If you're age banded with current carrier, please provide most recent billing statement.

8. Validations

Groups completing the Employer Risk Assessment Form may skip Sections A & B.

A. Serious Medical Conditions: As an employer are you aware of any employee or dependent of an employee, including those not enrolling for coverage, who has been diagnosed or treated for a serious health problem such as AIDS, HIV positive status, Alzheimer Disease, Cancer, Diabetes, Heart Attack or Heart Disease, Hemophilia, Kidney Disease, Mental Illness or Substance Abuse? ☐ Yes ☐ No If yes, provide details below. (Attach separate sheet of paper if needed)

Patient Name	Aggregate Dollar Amount of Claims	Dates of Service	Describe Illness or Condition

B. Has anyone within the past 24 months been hospitalized, institutionalized or missed work due to any disability or work related injury?
☐ Yes ☐ No If yes, provide details below.

Patient Name	Describe Illness or Condition

C. Is anyone currently COBRA eligible/enrolled?
☐ Yes ☐ No If yes, provide details below.

Name	Social Security #	Beginning Date	Expiration Date	Qualifying Event

D. Are there any retirees who meet the eligibility requirements AND are members of a formal retirement program?
☐ Yes ☐ No If yes, provide details below.

Name	Social Security #	Age at Retirement	Date of Retirement	Date of Hire	Avg. Hrs. Worked Per Week Prior to Retirement

WARNING: Any person who, with intent to defraud or knowing that he is facilitating a fraud against and insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. (Ohio Revised Code Section 39999.21)

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9. Terms and Conditions

1. The group named herein, which is duly organized under the laws of the State of Ohio, hereby applies to Medical Mutual of Ohio (MMO) and/or Consumers Life Insurance Company (CLIC) for the benefits selected herein. The group understands and acknowledges that the actual benefits will be specified in the group contract if this application is accepted by MMO, and that benefits will take effect as of the date specified in such group contract. **This Employer/Group Enrollment Application is not a contract for healthcare benefits. Continue your current coverage until you are notified in writing that MMO has accepted this application.**
2. For all groups: Each employee not enrolling must complete the Waiver on the cover page of the Employee Application and Change Form and Medical History Questionnaire. For groups with 1 - 50 members: Each employee enrolling must complete all sections of the Employee Application and Change Form and Medical History Questionnaire (Sections 1 - 9).
3. To be eligible for coverage, an individual must be a full time employee of the group or company applying for coverage. Any individual who applies for insurance coverage from MMO and/or CLIC must be a full-time common law employee, drawing a regular paycheck and with compensation reported on IRS Form W-2. Independent contractors of the group or company are not eligible for coverage.
4. To be eligible for coverage by MMO and/or CLIC, the group or company must be in compliance with all applicable laws of the State of Ohio.
5. Any untrue or incomplete information, statements or answers on this application (whether intentional or not) or engaging in any fraudulent conduct, deception or misrepresentation relating to any application, coverage, claim or usage of a MMO identification card can result in denial of a claim or recision of coverage for the group or any group member, and may subject the group or any group member to legal action by MMO and/or CLIC.
6. Approval and acceptance of this Employer/Group Enrollment Application and individual Employee Applications are subject to MMO and/or CLIC underwriting guidelines.
7. It is agreed that this Employer/Group Enrollment Application supersedes any previous applications for this group coverage.
8. By signing this Employer/Group Enrollment Application, the authorized representative of the group or company represents that the group or company is not an entity that has been formed primarily to obtain health insurance coverage, and it does not permit membership in the group or company solely for the purpose of obtaining health insurance coverage.
9. The group hereby authorizes MMO and/or CLIC to obtain information from prior carriers to determine existence of pre-existing conditions. Prior carriers are authorized to release such information to MMO and/or CLIC upon receipt of a copy of this application.
10. The group or company hereby appoints the Secretary of MMO and/or CLIC as its proxy with power of substitution, to act for and on its behalf at any and every annual meeting or any special meeting of the members of MMO and/or CLIC. The group or company authorizes its proxy to vote and act for and on behalf of the member at such meeting as fully and to the same extent as the member could do if present thereat. This proxy shall continue in force until ten years from the date hereof unless sooner revoked by a notice in writing signed by the group and delivered to MMO and/or CLIC.
11. I understand and agree that no agent or broker has the authority: (a) to bind MMO and/or CLIC by making promises regarding eligibility, benefits, or the issuance of a policy; (b) to waive any answer or any portion of any answer to any question on this application or any information MMO and/or CLIC requests; (c) approve coverage; (d) make or alter any contract on behalf of MMO and/or CLIC; or (e) waive or alter any of MMO and or CLIC's other rights or requirements. All contract terms must be in writing and signed or accepted in writing by an authorized representative of MMO and/or CLIC to be binding on MMO and/or CLIC.

10. Authorized Signature (Please print)

Business Name	Name (print)	Title
Authorized Signature		Date
Broker Signature (if applicable)	Broker Name (print) (if applicable)	
Federal Tax ID	Royal Advantage Broker	

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Cleveland OH 44115-1355

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