

EMPLOYER/GROUP ENROLLMENT APPLICATION

for fully insured groups

THIS IS AN APPLICATION FOR COVERAGE, NOT A CONTRACT.
DO NOT CANCEL YOUR CURRENT COVERAGE UNTIL YOU HAVE RECEIVED WRITTEN ACCEPTANCE FROM MMO.
NOTE: If your group is accepted, MMO cannot provide retroactive effective dates.

1. GROUP/COMPANY INFORMATION

GROUP NAME		EIN/FEDERAL TAX ID #		MMO GROUP #	
HAS THIS GROUP EVER BEEN KNOWN BY ANOTHER NAME? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, WHAT NAME(S):					
DUN & BRADSTREET #					
ADDRESS					
CITY		COUNTY		STATE	
ZIP CODE		PHONE NUMBER		Ext.	
CHIEF EXECUTIVE		BILLING CONTACT		RENEWAL CONTACT	
SIC CODE		TYPE OF BUSINESS (be specific)		HAS THIS GROUP EVER APPLIED TO MMO BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO	
				WHEN? YEARS IN BUSINESS	

2. ENROLLMENT CRITERIA

ELIGIBLE EMPLOYEE PROFILE	Minimum # of Hours Worked per week to be considered eligible for Health Care Benefits* _____	Probation Period for Health Care Benefits (in days) New Hires _____ Rehires _____
Are there any other employer imposed eligibility requirements? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe.		
EMPLOYER CONTRIBUTIONS Check \$ or % for each category and specify amount.	MEDIFIL <input type="checkbox"/> % <input type="checkbox"/> \$	SINGLE <input type="checkbox"/> % <input type="checkbox"/> \$
	2 - PERSON <input type="checkbox"/> % <input type="checkbox"/> \$	FAMILY <input type="checkbox"/> % <input type="checkbox"/> \$
DO YOU HAVE ANY AFFILIATIONS WITH OTHER COMPANIES OR UNIONS (include parent, subsidiary, joint venture, etc...)? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE DESCRIBE.		
PARTICIPATION	Active**	COBRA
Total Number of Current Employees (part time & full time)		
Total Number of Eligible Employees		
Number of Employees Applying for Coverage		
Total Number of Ineligible Employees		

* Minimum must be between 20 and 25 hours for groups with 2-50 employees. Minimum must be equal to or greater than 20 hours for groups with 51-99 employees.
** Including Owners, Officers and Partners who receive compensation from the company, reported on a tax form other than a 1099.

3. STANDARD BENEFIT OPTIONS - WEST (check appropriate box(es))

GROUP SIZE ENROLLING	BENEFIT PROGRAMS
(Those Benefits available to a group size are offered in addition to those Benefits available to smaller group sizes.)	
2+	<ul style="list-style-type: none"> • Winning: <input type="checkbox"/> 1000 <input type="checkbox"/> 2000 <input type="checkbox"/> 2400 <input type="checkbox"/> 3000 BBB: <input type="checkbox"/> 250/500 <input type="checkbox"/> 600/1200 • SuperMed Classic: <input type="checkbox"/> 1000 <input type="checkbox"/> 2000 <input type="checkbox"/> 2400 <input type="checkbox"/> 3000 BBB: <input type="checkbox"/> 250/500 <input type="checkbox"/> 600/1200 • SuperMed Plus: <input type="checkbox"/> 1000 <input type="checkbox"/> 2000 <input type="checkbox"/> 2400 <input type="checkbox"/> 3000 BBB: <input type="checkbox"/> Option I, Dep. 25, DME, \$10 Drug
10+	<ul style="list-style-type: none"> • Winning: <input type="checkbox"/> 4000 <input type="checkbox"/> 5000 • SuperMed Classic: <input type="checkbox"/> 4000 <input type="checkbox"/> 5000 • SuperMed Select: <input type="checkbox"/> Option II <input type="checkbox"/> Option III <input type="checkbox"/> Managed Care Drug • SuperMed Plus: <input type="checkbox"/> 4000 <input type="checkbox"/> 5000 • Dental: <input type="checkbox"/> Dental Option I • Drug Program: <input type="checkbox"/> Traditional <input type="checkbox"/> Scriptnet <input type="checkbox"/> Select • Drug Deductible: <input type="checkbox"/> \$5 <input type="checkbox"/> \$10 • Additional Coverages: <input type="checkbox"/> Vision • HMO Health OhioSM: <input type="checkbox"/> Standard <input type="checkbox"/> Option I <input type="checkbox"/> BBB Option I, Dep. 25, DME <input type="checkbox"/> Vision \$75 <input type="checkbox"/> \$10 Drug <input type="checkbox"/> \$5
25+	<ul style="list-style-type: none"> • Dental: <input type="checkbox"/> Option II
51+	<ul style="list-style-type: none"> • SuperMed Select: <input type="checkbox"/> Option I, IV, VI • Other: <input type="checkbox"/> Non-Standard Benefits (a PAP is Required)

PROPOSED EFFECTIVE DATE FOR COVERAGE TO START: / /

If more space is needed for Sections 4 or 5, attach an additional sheet in the same format.

4. CURRENT and PRIOR CARRIER HISTORY (If more space is needed, attach an additional sheet in the same format.)

List all carriers used for all product lines offered to the employees for the past 5 years. If there are no carriers, indicate NONE.

CARRIER NAME (Current Carrier First)	CHECK IF CONTINUING COVERAGE	TYPE OF PLAN*	TYPE OF BENEFIT**	DATES		CURRENT RATES				RENEWAL RATES***			
				From	To	Single	2-Person	Family	Medicare	Single	2-Person	Family	Medicare
1.	<input type="checkbox"/>												
2.	<input type="checkbox"/>												
3.	<input type="checkbox"/>												

* Examples: Traditional, HMO, PPO, etc... **Examples: Comp. Major Med., 1st Dollar, etc... *** For the current carrier and any continuing coverage.

5. VALIDATIONS (If more space is needed, attach an additional sheet in the same format.)

Groups completing the Employer Risk Assessment Form may skip 5A and B.

A • **SERIOUS MEDICAL CONDITIONS:** As an employer are you aware of any employee or dependent of an employee, including those not enrolling in MMO coverage, who has been diagnosed or treated for a serious health problem such as AIDS, HIV Positive Status, Alzheimer's Disease, Cancer, Diabetes, Heart Attack or Heart Disease, Hemophilia, Kidney Disease, Mental Illness or Substance Abuse? YES NO If Yes, provide details below.

PATIENT NAME	DATE OF BIRTH	RELATIONSHIP TO EMPLOYEE	AGGREGATE DOLLAR AMOUNT OF CLAIMS	DATES OF SERVICE	DESCRIBE ILLNESS OR CONDITION (include Worker's Compensation #)

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	DOB	REL. TO EMP.	DESCRIBE ILLNESS OR CONDITION

C • **IS ANYONE CURRENTLY COBRA Eligible/Enrolled?** YES NO If Yes, provide details below.

NAME	SOCIAL SECURITY #	DATE OF QUALIFYING EVENT	EXPIRATION DATE	QUALIFYING EVENT

D • **ARE THERE ANY RETIREES** who meet the eligibility requirements? 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

6. TERMS, CONDITIONS AND DESIGNATION OF PROXY

- The group named herein, which is duly organized under the laws of the State of Ohio, hereby applies to Medical Mutual of Ohio (MMO) 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 health care benefits. Continue your current coverage until you are notified in writing that MMO has accepted this application.**
- For all groups: Each employee not enrolling must complete the Waiver on the cover page of the Employee Application, Change Form and Medical History Questionnaire. For groups with 1 - 24 members: Each employee enrolling must complete all sections of the Employee Application, Change Form and Medical History Questionnaire (Sections 1 - 9).
- 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 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.
- To be eligible for coverage by MMO, the group or company must be in compliance with all applicable laws of the State of Ohio.
- 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 rescission of coverage for the group or any group member, and may subject the group or any group member to legal action by MMO, HMO Health Ohio or Medical Life Insurance Company.
- Approval and acceptance of this Employer/Group Enrollment Application and individual Employee Applications are subject to MMO underwriting guide lines.
- It is agreed that this Employer/Group Enrollment Application supersedes any previous applications for this group coverage.
- 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.
- The group hereby authorizes MMO and MLI to obtain information from prior carriers to determine existence of pre-existing conditions. Prior carriers are authorized to release such information to MMO or MLI upon receipt of a copy of this application.
- The group or company hereby appoints the Secretary of MMO 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. 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.

7. AUTHORIZED SIGNATURE

PRINT NAME and TITLE of the authorized representative who has full power and authority to legally bind and act on behalf of the group.	BROKER if applicable
SIGNATURE of the AUTHORIZED REPRESENTATIVE I certify that I understand the contents of this application and that the information stated herein is true and correct and that I will promptly notify MMO of any changes.	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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To Whom It May Concern:

In order to complete the quoting process for a new group submission the following information is required:

1. Employer/Group Enrollment Application must be filled out completely (ALL QUESTIONS MUST BE ANSWERED). Current and prior carrier history/rates must be provided.
2. Tax document/OBES (prior quarter)/affidavit must be reconciled. All employees must be accounted for and status identified i.e. full-time, part-time, retired, COBRA, terminated. Affidavit will be accepted only if the group has been in business for less than one year. It must be signed and dated by a licensed notary. COBRA/state continuation eligible employees must have either a waiver or application.
3. Valid waivers:
 - * spousal waiver
 - * Kaiser/COSE
 - * other MMO coverage.A waiver needs to be filled out if employee is waiving their dependents.
4. Employee applications and medical health questionnaires must be filled out in their entirety (all sections completed, including spousal social security numbers, birthdates and heights and weights). All YES answers in 6A and 6B MUST be explained in 6C.
5. MMO apps must be dated and signed within 90 days of submission.
6. Participation issues must be addressed prior to any quote.

ALL OF THE ABOVE INFORMATION MUST BE COMPLETED PRIOR TO REVIEW BY UNDERWRITING.

Thank you in advance for your cooperation,

Medical Mutual Underwriting