Employer Group Enrollment Application/Change Form

☐ initial enrollment ☐ change

1. Group/Company Information

Business Name					Requested Effective Date
Has this business ever been known by another name? ☐ Yes ☐ No If yes, what name(s)?					Medical Mutual 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.)				Plan Year
Type of Business (be specific)	SIC Code			Employer/Federal Tax ID #	

Has group ever applied with Medical Mutual? ☐ Yes ☐ No If so, when?___________________________________

Is plan grandfathered? ☐ Yes ☐ No

Is the plan subject to ERISA? ☐ Yes ☐ No (Check the applicable box below)

- ☐ Government entity (i.e., city, county, township, public school district)
- ☐ Church plan
- ☐ Group of one (self employed)
- ☐ Other: ____

Do you have any affiliations with other companies or unions (include parent, subsidiary, joint venture, etc...) ?

☐ Yes ☐ No If yes, please describe. ____

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.

____

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

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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*___________________

Per ACA guidelines, your group probationary period may not exceed 90 calendar days. Therefore, eligible members electing coverage shall be effective no later than their 91st calendar day of employment.

☐ Date of Hire
☐ First of month following Date of Hire
☐ 30 calendar days following Date of Hire
☐ First of month following 30 calendar days
☐ 60 calendar days following Date of Hire
☐ First of month following 60 calendar days
☐ 90 calendar days following Date of Hire
☐ Other (not to exceed 90 calendar days from Date of Hire _____________

Waive probationary period for initial enrollment? ☐ Yes ☐ No

* Minimum must be 30 hours per week, for full time eligibility. **Including owners, officers and partners who receive compensation from the company, reported on a tax form other than a 1099.

Are there any other employer imposed eligibility requirements? ☐ Yes ☐ No
If "yes", explain: ________________________
____

Employer Contributions	Single	2-Person	Family	Retiree
(Check box and specify amount)	☐ ______%	☐ ______%	☐ ______%	☐ ______%

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

Provide details below for anyone currently eligible or enrolled in COBRA.

Name	Social Security #	Beginning Date	Expiration Date	Qualifying Event

Provide details below for any retirees who meet the eligibility requirements AND are members of a formal retirement program?

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

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3. Recent Health Changes (respond for groups with 51+ eligible employees only)

Are you aware of any medical conditions present for enrolling members that may not yet have been disclosed to Medical Mutual during the past 90 days? ☐ Yes ☐ No

If yes, please describe____

4. Products (respond for groups with fewer than 51+ eligible employees only)

Medical, dental and vision benefits

(Groups with 51 or more employees are required to sign a separate benefit highlight form reflecting benefits desired. Therefore, this product selection area is not required to be completed.)

Health Plan Options

Gold Plan Options
☐ Gold 2000 HSA/HRA
☐ Gold 2520-1000
☐ Gold 2520-2000

Silver Plan Options
☐ Silver 1500
☐ Silver 2750 HSA
☐ Silver 3020-4000
☐ Silver 3500-5000 HSA/HRA
☐ Silver 3500-6500 HSA/HRA
☐ Silver 4000 HSA
☐ Silver 5000 ES-HSA
☐ Silver 6500 HSA/HRA

Bronze Plan Options
☐ Bronze 4000 HSA
☐ Bronze 4040-6000
☐ Bronze 5000 HSA
☐ Bronze 6000 HSA

Dental Plan Options*
(All Plans Include Pediatric Dental)**

	Ortho Rider (10+ employees)
☐ Dental Plan 3	
☐ Dental Plan 3 (Voluntary)	
☐ Dental Plan 4	☐
☐ Dental Plan 5	
☐ Dental Plan 6	☐
☐ Dental Plan 6 (Voluntary)	
☐ Dental Plan 7	☐
☐ Dental Plan 7 (Voluntary)	
☐ Dental Plan 8	☐
☐ Dental Plan 9	☐

Vision Plan Option*
☐ EyeMed Vision

*Dental and Vision plans can be purchased without medical as stand-alone products.

**The Affordable Care Act requires that small employers offer pediatric dental benefits to their employees and dependents. Therefore, this coverage must be included unless proof of pediatric dental benefits through another carrier is provided. Such proof must be included with this application to Medical Mutual. If proof is not received, pediatric dental benefits (Pediatric Dental 1) and the corresponding premiums will be included in the plan selected above. If a Medical Mutual Dental Plan is purchased, Pediatric Dental will be included.

5. Employer Funding

Is any part of the employee's or dependent's deductible being funded by the employer or from an employer-established account? ☐ Yes ☐ No If so, how much? Single: ________ Family: ________

Does the employer fund first? ☐ Yes ☐ No

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6. Life, AD&D, Dependent Life and Short-Term Disability

☐ Yes I am electing life and/or short-term disability coverage in accordance with proposal number _______________________, incorporated by reference in and made part of this application for all purposes.
If multiple plans are indicated on the proposal, indicate plan option elected ___________________.

The requested effective date will be as stated in the above-mentioned proposal, unless indicated below:

_________________________________.

If the Company approves this application, a policy will be issued. The applicant agrees that acceptance of the Policy will be approval of the Policy terms.

Participation-free coverage
☐ Yes, I am electing participation-free Voluntary Life and AD&D
☐ Yes, I am electing participation-free Voluntary Life, AD&D and short-term disability.
If participation-free, voluntary short-term disability is elected, indicate the plan: _ 1/8/13 _ 1/8/26

Waiting period is identical to medical probationary period, unless indicated below:
☐ None
☐ First of month following completion of _____ days
☐ Other ___________________________________

Employees working less than 20 hours per week are not eligible for coverage. If different than 20 hours, please indicate number of hours:___________

Employer contribution percentages (%) for all products are stated in the proposal, unless indicated below:

Product	%	Product	%

Group Long-Term Disability

☐ Yes I am electing group long-term disability coverage in accordance with proposal number _______________________, incorporated by reference in and made part of this application for all purposes.
If multiple plans are indicated on the proposal, indicate plan option elected ___________________.

The requested effective date will be as stated in the above-mentioned proposal, unless indicated below:

_________________________________.

If the Company approves this application, a policy will be issued. The applicant agrees that acceptance of the Policy will be approval of the Policy terms.

Prior carrier: ____
(Prior carrier must be listed and a copy of the prior policy included for **continuity of coverage** to apply.)

Termination date of prior policy: ____________________________________

Waiting period – present employees: __________________________________

Waiting period – future employees: ___________________________________

Employees working less than 30 hours per week are not eligible for coverage. If different than 30 hours, please indicate number of hours: _________ .

Contribution:
Employer _______% Employee _______% ☐ Pre-tax dollars ☐ Post-tax dollars

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		Current Rates**				Renewal Rates**			
			From	To	Emplye	Spouse	Child	Family	Emplye	Spouse	Child	Family
	☐											
	☐											
	☐											

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

8. Terms and Conditions

I, as the undersigned employer or other eligible membership organization duly organized under the laws of the State of Ohio, hereby apply to Medical Mutual of Ohio and/or one of its wholly owned subsidiaries, Medical Health Insuring Corporation of Ohio or Consumers Life Insurance Company, collectively referred to as "Medical Mutual for coverage."

I understand, acknowledge and agree to the following:

- **This Employer Group Enrollment Application and Change Form ("Application") is not a contract for benefits. I should continue my current coverage until I am notified in writing that Medical Mutual has accepted this Application.**
- If this Application is accepted by Medical Mutual, the actual benefits will be specified in the group contract(s) and that said benefits will take effect on the date specified in a communication from the applicable carrier(s) underwriting my group coverage.
- For all groups, each employee not enrolling must complete the waiver section of the applicable employee application.
- Only my full-time employees are eligible for coverage. All individuals who apply for insurance coverage from Medical Mutual must be full-time, common-law employees, drawing a regular paycheck, whose compensation is reported on IRS Form W-2. Independent contractors are not eligible for coverage. For life and/or disability benefits only, being Actively at Work (as described earlier in this Application and defined in the group policy) 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 life and/or disability 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.
- To be eligible for coverage, I must comply with all applicable laws of the State of Ohio. By applying for coverage, I agree that Medical Mutual may, from time to time, verify my compliance with the underwriting eligibility or participation standards of the pertinent program. I agree to provide payroll records if requested by Medical Mutual or any other carrier to verify my compliance.
- Any untrue or incomplete information, statements or answers on this Application (whether or not intentional) or engaging in any fraudulent conduct, deceptions or misrepresentation relating to any application, coverage, claim or usage of a carrier identification card, can result in denial of a claim or rescission of coverage for me or any group member, and may subject me or any group member to legal action by Medical Mutual. I have a duty to notify Medical Mutual of any changes to the information contained in this Application.
- Approval and acceptance of this Application and individual employee applications are subject to Medical Mutual's underwriting guidelines, as permitted by law. Checking the boxes does not cause automatic enrollment. Medical Mutual must approve this Application.
- This Application shall be made part of the policy for which application is made and supersedes any previous applications for this group coverage.
- By signing this Application, I represent that this group or company is not an entity that has been formed primarily to obtain insurance coverage, and it does not permit membership in this group or company solely for the purpose of obtaining insurance coverage.
- I authorize Medical Mutual to obtain information from prior carriers to determine existence of pre-existing conditions. Prior carriers are authorized to release such information to Medical Mutual upon receipt of a copy of this Application. Medical Mutual collects this data as a service to you.

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8. Terms and Conditions (continued)

- No agent or broker has the authority to: (1) bind Medical Mutual by making promises regarding eligibility, benefits, or the issuance of a policy; (2) waive any answer or any portion of any answer to any question on this Application or any information Medical Mutual requests; (3) approve coverage; (4) make or alter any contract on behalf of Medical Mutual; or (5) waive or alter any of Medical Mutual'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 to be binding on Medical Mutual.

- The group or company hereby appoints the Secretary of Medical Mutual of Ohio 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 Medical Mutual of Ohio. 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 Medical Mutual of Ohio.

9. Authorized Signature (Please print)

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

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)