

**READ CAREFULLY AND COMPLETE IN INK TO PREVENT YOUR COVERAGE FROM BEING DELAYED**  
**IF YOUR GROUP HAS LESS THAN 50 MEDICAL LIVES, COMPLETE THIS APPLICATION IN FULL.**  
**IF YOUR GROUP HAS BETWEEN 50 AND 100 MEDICAL LIVES, COMPLETE ALL SECTIONS EXCEPT SECTION #4.**  
**IF YOUR GROUP HAS MORE THAN 100 MEDICAL LIVES, COMPLETE ALL SECTIONS EXCEPT SECTION #3, SECTION #4, SECTION #5 AND SECTION #6.**  
**IF WAIVING ANY COVERAGE(S), COMPLETE AND SIGN SECTION #7, AND OTHER SECTIONS AS STATED ABOVE.**  
**IF APPLYING FOR SPOUSE COVERAGE, HAVE YOUR SPOUSE SIGN AND DATE THE STATEMENT AND AUTHORIZATION IN SECTION #8.**

**1**  
**ADD SPOUSE**  
**ADD CHILDREN**

Employer \_\_\_\_\_ Employee \_\_\_\_\_  
 Account No. \_\_\_\_\_ Social Security Number \_\_\_\_\_ Telephone ( ) \_\_\_\_\_  
 Name \_\_\_\_\_ Hgt/Wgt \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Date of Marriage \_\_\_\_\_ Spouse employed  Yes  No Spouse's S.S. No. \_\_\_\_\_  
 Employed By \_\_\_\_\_  
Company Name City, State of Employment  
 Spouse insured elsewhere?  Yes  No If yes, Insured By \_\_\_\_\_ Policy Number: \_\_\_\_\_

Full Name	Date of Birth	Height/Weight	S.S. Number	Relationship (Check One)				You &/or your Spouse provide over 50% of Support?	Full-Time Student? (Y/N)
				Natural Child	Adopt Child*	Step-Child	Legal Guard.*		

*\*Please attach to this application copies of the court orders or legal documents creating this relationship.*  
 Children Insured elsewhere?  Yes  No If yes, Insured by: \_\_\_\_\_ Policy Number: \_\_\_\_\_  
 Are any of the other Dependents listed above in the legal custody of another Person?  Yes  No  
 If yes:

Dependent	Person with Legal Custody	Relationship to Dependent	Address of Custodian

If you are the legal guardian, but not the parent, of any child listed above, does each such child reside with you?  Yes  No If no, which children do not? \_\_\_\_\_

**CHANGE MARITAL STATUS** From  Single  Divorced  Separated To  Married  Divorced  Married  Widowed  Separated  Widowed  
 (If changed to "Married" and spouse is not added to coverage, please complete Section 8.)

**NAME CHANGE**  Employee Name  Dependent's Name \_\_\_\_\_  
(Dependent's former name)  
 By marriage  Other, describe \_\_\_\_\_  
 Change Name to \_\_\_\_\_

**CHANGE ADDRESS** New Address \_\_\_\_\_

**CHANGE BENEFICIARY** Full Name \_\_\_\_\_ Relationship \_\_\_\_\_  
(Give names: Mary A. Smith, NOT Mrs. John L. Smith)

**DELETE DEPENDENTS**  Delete Spouse Name \_\_\_\_\_ As of \_\_\_\_\_  
 Delete Child(ren) Name \_\_\_\_\_ As of \_\_\_\_\_  
 Name \_\_\_\_\_ As of \_\_\_\_\_

**DELETE EMPLOYEE COVERAGE**  Delete All Coverage As of (indicate last day of work) \_\_\_\_\_  
 Delete Dental/Vision As of \_\_\_\_\_  
 Delete Medical Coverage As of \_\_\_\_\_

**NOTICE REGARDING PRIOR HEALTH COVERAGE**

If any person for whom application for coverage has been made above was covered under other health coverage within 62 days (not including any waiting period under this plan or any other plan) of the date such person's coverage would become effective under this plan, he or she may be entitled to credit towards any pre-existing conditions restriction under the Medical Benefits Mutual plan for any coverage time under the prior plan. In order to claim this credit, a certificate of coverage from the prior plan, or other evidence documenting the person's prior coverage, should be attached to this form.

If coverage was lost under the prior health plan within 30 days of the date of this application, list reason the coverage was terminated under the prior plan. \_\_\_\_\_

**FOR OFFICE USE ONLY** CHANGE EFFECTIVE: \_\_\_\_\_ EXCLUSIONS: \_\_\_\_\_  
 DATE PROCESSED: \_\_\_\_\_ ISSUED: \_\_\_\_\_

**3**

A.  Yes  No Have you or any dependents (to be covered) incurred medical expenses in excess of \$4,000.00 or made claims in the past five (5) years?

B.  Yes  No Are you or any dependents (to be covered) currently pregnant? If "yes", give due date and any past or known current complication in Section 6 on back.

C.  Yes  No Are you or any dependents (to be covered) currently disabled, missed work or been unable to perform your regular daily activities for more than 5 consecutive days because of any illness or injury (including pregnancy) during the past two (2) years?

D.  Yes  No Other than the above, have you or any dependents (to be covered) ever been treated for or had any indication of serious illness, injury or developmental birth defect, such as, but not limited to, heart disease, kidney disease, cancer, or stroke, or been positively diagnosed or treated for AIDS or AIDS-related complex?

E.  Yes  No Within the past 5 years, have you or any of your dependents (to be covered) had any injury or condition for which you sought or received workers' compensation benefits?

F.  Yes  No Are you or any dependents (to be covered) presently ill, taking medication, receiving treatment or been advised or a condition that will require medical treatment or surgery in the next 12 months?

**4** Have you or any dependents (to be covered) ever been treated for, or had any indication of:

	Yes	No	Condition		Yes	No	Condition		Yes	No	Condition
1)	<input type="checkbox"/>	<input type="checkbox"/>	diabetes/endocrine disorder	9)	<input type="checkbox"/>	<input type="checkbox"/>	asthma/respiratory disorder	17)	<input type="checkbox"/>	<input type="checkbox"/>	high/low blood pressure
2)	<input type="checkbox"/>	<input type="checkbox"/>	tumor	10)	<input type="checkbox"/>	<input type="checkbox"/>	surgeries	18)	<input type="checkbox"/>	<input type="checkbox"/>	sexually transmitted diseases
3)	<input type="checkbox"/>	<input type="checkbox"/>	liver disorder	11)	<input type="checkbox"/>	<input type="checkbox"/>	prostate trouble	19)	<input type="checkbox"/>	<input type="checkbox"/>	second or third degree burns
4)	<input type="checkbox"/>	<input type="checkbox"/>	bladder disorder	12)	<input type="checkbox"/>	<input type="checkbox"/>	head/neck/spinal/back disorder	20)	<input type="checkbox"/>	<input type="checkbox"/>	epilepsy/seizure disorders
5)	<input type="checkbox"/>	<input type="checkbox"/>	nervous/psychiatric disorder	13)	<input type="checkbox"/>	<input type="checkbox"/>	high risk pregnancies/infants	21)	<input type="checkbox"/>	<input type="checkbox"/>	eye, ear, nose or throat trouble
6)	<input type="checkbox"/>	<input type="checkbox"/>	arthritis	14)	<input type="checkbox"/>	<input type="checkbox"/>	alcohol or drug abuse	22)	<input type="checkbox"/>	<input type="checkbox"/>	other serious or chronic diseases or conditions
7)	<input type="checkbox"/>	<input type="checkbox"/>	multiple trauma	15)	<input type="checkbox"/>	<input type="checkbox"/>	gallbladder/digestive disorder				
8)	<input type="checkbox"/>	<input type="checkbox"/>	blood/immune system disorder	16)	<input type="checkbox"/>	<input type="checkbox"/>	heart/cirulatory disorders				

**5 COMPLETION OF SECTION #5 IS MANDATORY FOR ANY "YES" ANSWERS IN SECTIONS #3 or #4**

If any of the questions or conditions are checked "yes", please explain below (use additional paper if necessary). Please indicate specific location of condition (example: right knee), details of injury, ailment or condition.

Question Number/ Letter	Person Treated	Diagnosis and Type of Treatment	Hospitalized Yes/No	Dates of Treatment	Names and Phone Numbers of Attending Physicians

**6** Below, list all medications you or your dependents (to be covered) are taking or have taken over the last 5 years. **IF NONE, CHECK HERE:**

Name of Person	Medication/Amounts per Day	For What Condition	Currently Taking

**7 WAIVER OF COVERAGE**

All eligible employees must enroll for Life and AD&D, and if included in the employer's plan, Disability coverage.

**If you are declining enrollment for yourself or your dependents (including your spouse) because you have 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 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, placement for adoption, or your appointment as a legal guardian, you may be able to enroll yourself and/or your dependents, provided that you request enrollment within 30 days after the date of the marriage or appointment of legal guardianship, or 31 days of a birth, adoption, or placement for adoption,. This plan will also allow enrollments as necessary to comply with the terms of medical child support orders, or qualified medical child support orders, as defined in applicable state or federal law. Other than as described above, you may not be eligible to enroll in this plan if you waive coverage at this time or may be subject to an additional waiting period, beginning with the date of late enrollment.**

I waive coverage for:  All Medical Coverage  Dependent Medical  Other \_\_\_\_\_  
 All Dental/Vision  Dependent Dental/Vision

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

Are you waiving the coverage listed above because you and/or your dependents have other health coverage?  Yes  No  
 With whom? \_\_\_\_\_

**8 Read this Statement and Authorization Carefully**

I hereby request coverage and authorize that any requested contribution for the insurance to which I may be entitled be deducted from my earnings. I am employed by the employer shown and am working at least the number of hours per week required by my Employer and shown on the Employer Application. I further understand that any failure to comply with the Utilization Review or Second Surgical Opinion procedures may result in a reduction of benefits. I authorize (1) any physician, hospital, or other health practitioner or facility, (2) any insurance company or health care plan, (4) any state or federal agency providing health care benefits; and (4) any employer to provide Medical Benefits Mutual Life Insurance Co. or its legal representative any information in their possession which is relevant to this application for insurance regarding myself or my listed Dependent(s). This information will be used to determine the eligibility for coverage and/or benefits for myself and my listed Dependent(s) and will be utilized by employees and agents of Medical Benefits Mutual Life Insurance Co. with responsibility for (1) reviewing applications and determining eligibility for coverage, and (2) payment of claims. I hereby authorize any provider or health care services, claim administrators, insurers, reinsurers, and others who have a legitimate need for such information for the purpose of review, investigation, or evaluation of a claim, to supply each other with information about the health status of, and health care services provided to, me and my listed dependents. This authorization is effective on the date signed and shall remain in effect for 30 months from that date. (You or any individual authorized by law to act on your behalf have a right to receive a copy of this authorization). A photographic copy of this authorization shall be as valid as the original. I hereby certify that I have personally answered all of the questions on this form and that my answers are true and complete to the best of my knowledge and belief. I have legal proof which I can furnish upon request of my relationship to any person listed as a Dependent(s) above. I understand any misstatements or failure to report may be used as a basis for rescission or cancellation of the insurance for me and my Dependent(s), if any.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

Spouse Signature (if applying for coverage) \_\_\_\_\_ Date \_\_\_\_\_

I understand that if, upon receipt, the signature is more than 60 days old, a new application will be requested.