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WARNING: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statements is guilty of insurance or health care fraud under state and/or federal law.

- Change New Application
- Coverages Elected**
 Medical
 Dental
 Vision
 LTD
 Life/AD & D

EMPLOYEE APPLICATION

For Office Use Only	Group No. _____ Acct. No. _____ Employee Eff. _____ Exclusions _____
	Coinsurance Plan _____ Ded. _____ Option _____ Area _____ Tier _____ Mat _____
	Life/AD&D _____ WL/LTD _____ Vision _____
	PPO _____ PCS _____ Dental _____ Orth _____ # of Medical Lives _____

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 #5.
 IF YOUR GROUP HAS MORE THAN 100 MEDICAL LIVES, COMPLETE ALL SECTIONS EXCEPT SECTION #4, SECTION #5, SECTION #6 AND SECTION #7.
 IF WAIVING ANY COVERAGE(S), COMPLETE AND SIGN SECTION #8, AND OTHER SECTIONS AS STATED ABOVE.
 IF APPLYING FOR SPOUSE COVERAGE, HAVE YOUR SPOUSE SIGN AND DATE THE STATEMENT AND AUTHORIZATION IN SECTION #9.

1

Employee Information (Please Print in Ink): Social Security Number _____

Name _____
Last First Middle Initial

Home Address _____ Telephone () _____
Street City State Zip

Employee Date of Birth _____/_____/_____ Mo. Day Yr.	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female Height _____ Weight _____	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Common Law*	Who is to be Insured** <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee and Spouse <input type="checkbox"/> Employee and Children <input type="checkbox"/> Employee, Spouse & Children	Date Hired ____/____/_____ Mo. Day Yr COBRA Election Date ____/____/_____ Earnings _____ <input type="checkbox"/> Yearly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
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Employed by _____
Company Name City, State of Employment Group/Account Number

Occupation _____ Hours Worked Weekly _____

Beneficiary Name _____ Relationship _____
Last First

*Complete Supplemental Information - Common Law Relationship **If electing dependent coverage, all eligible dependents must apply.

2

IF APPLYING FOR DEPENDENT COVERAGE LIST BELOW
 Dependent coverage is not available for AD&D or Disability Insurance.
 If you do not wish to cover your eligible dependents, please complete the waiver area in Section #8.

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. *		
Spouse									
Other Dependent(s)									

*Please attach to this application copies of the court orders or legal documents creating this relationship.

Spouse employed Yes No Employed By _____ Date of Marriage _____
 Spouse Insured elsewhere? Yes No If yes, Insured By _____ Policy Number: _____
 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? _____

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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 creditable 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. _____

- 4**
- 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.
 - 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 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 of a condition that will require medical treatment or surgery in the next 12 months?

5

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

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

6 COMPLETION OF SECTION #6 IS MANDATORY FOR ANY "YES" ANSWERS IN SECTIONS #4 AND #5

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

7 Below, list all medications you or your dependents 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

8 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 _____

9 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, (3) 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 of 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.