MedBen
Where peace of mind is your best benefit®

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 REQUEST FORM

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.

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Employer _____ Employee _____

Account No. _____ Social Security Number _____ Telephone ( ) _____

ADD SPOUSE

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: _____

ADD CHILDREN

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 _____

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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 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. _____

_____

1975 Tamarack Road • Newark, OH 43055 • phone (800) 423-3151 • fax (740) 522-5002

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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?

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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)	❑	❑	diabetes/endocrine disorder	9)	❑	❑	asthma/respiratory disorder	17)	❑	❑	high/low blood pressure
2)	❑	❑	tumor	10)	❑	❑	surgeries	18)	❑	❑	sexually transmitted diseases
3)	❑	❑	liver disorder	11)	❑	❑	prostate trouble	19)	❑	❑	second or third degree burns
4)	❑	❑	bladder disorder	12)	❑	❑	head/neck/spinal/back disorder	20)	❑	❑	epilepsy/seizure disorders
5)	❑	❑	nervous/psychiatric disorder	13)	❑	❑	high risk pregnancies/infants	21)	❑	❑	eye, ear, nose or throat trouble
6)	❑	❑	arthritis	14)	❑	❑	alcohol or drug abuse	22)	❑	❑	other serious or chronic diseases or conditions
7)	❑	❑	multiple trauma	15)	❑	❑	gallbladder/digestive disorder				
8)	❑	❑	blood/immune system disorder	16)	❑	❑	heart/cirulatory disorders				

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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	Hospital-ized Yes/No	Dates of Treatment	Names and Phone Numbers of Attending Physicians

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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

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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

Employee Signature: _____ **Date** _____

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

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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 eligible for coverage 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 Surgicial 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 MedBen or its legal representative any information in their possession which is relevant to this application for coverage regarding myself or my listed Dependent(s). This information will be used to determine the eligiblity for coverage and/or benefits for myself and my listed Dependent(s) and will be utilized by employees, agents and business associates of MedBen with responsibility for (1) reviewing applications and determining eligiblity for coverage, and (2) process and/or payment of claims, and (3) any other health care operations. I hereby authorize and release any provider of health care services, claim administrators, insurers, reinsurers, pharmacy benefit managers, stop loss carriers, disease management service and/or wellness benefit providers, and other business associates who have a legitimate need for such information for the purpose of review, investigation, or evaluation of a claim, health plan service or any other health care operation, to supply each other with information about the health status of, and health care services provided to, me and my listed Dependent(s). I understand that information disclosed to individuals listed in the preceding paragraph pursuant to this authorization may be subject to redisclosure by such individuals and will no longer be protected by this authorization. This authorization is effective on the date signed and shall remain in effect until the date such coverage is terminated. (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 understand that if I fail to provide this authorization, MedBen will be unable to process my application for coverage. I understand that I have the right to revoke this authorization by submitting such revocation to MedBen's Chief Privacy Officer at the address listed on this application. Such revocation will not be effective to the extent that action has been taken in reliance upon this authorization prior to receipt of my revocation or to the extent that my coverage or a claim may be contested under applicable law. 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 recission 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.