

Employer Group Enrollment Application Participation Agreement/Change Form

initial enrollment change

1. Group/Company Information					
Business Name					
Has this business ever been known by another name? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what name(s)?					COSE 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.)			
Type of Business (be specific)		SIC Code		Employer/Federal Tax ID #	
Dun and Bradstreet # _____		Has group ever applied with MMO? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, when? _____			
Is the employer contribution at least 25% of each contract? <input type="checkbox"/> Yes <input type="checkbox"/> No					
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. _____					
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. _____					
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* _____		Probation Period for New Hire Benefits <input type="checkbox"/> Date of Hire <input type="checkbox"/> First of month following Date of Hire <input type="checkbox"/> 30 days following Date of Hire <input type="checkbox"/> First of month following 30 days		<input type="checkbox"/> 60 days following Date of Hire <input type="checkbox"/> First of month following 60 days <input type="checkbox"/> 90 days following Date of Hire Probation Period for Rehire <input type="checkbox"/> Same as above <input type="checkbox"/> Other _____	
Waive probationary period for initial enrollment? <input type="checkbox"/> Yes <input type="checkbox"/> No	* Minimum must be within 20 – 25 hours per week, for full time eligibility for groups with 50 or fewer eligible employees. ** Including owners, officers and partners who receive compensation from the company, reported on a tax form other than a 1099.				
Participation		Active**	COBRA	Retired**	
Total number of current employees (part time & full time)					
Total number of eligible employees					
Number of eligible employees applying for coverage					
Total number of ineligible employees					

3. Medical Mutual of Ohio® (Medical Mutual) Plans		Proposed Effective Date
Is the employer contribution at least 25% of each contract: <input type="checkbox"/> Yes <input type="checkbox"/> No		
SUPERMED PLUS Multiple Option: <input type="checkbox"/> 100 Plan <input type="checkbox"/> 90 Plan <input type="checkbox"/> 80 Plan (Prescription Drug Card Included)		
SUPERMED PLUS: <input type="checkbox"/> 250/500 <input type="checkbox"/> 500/1000 <input type="checkbox"/> 750/1500 <input type="checkbox"/> 1000/2000 <input type="checkbox"/> 1000/3000 <input type="checkbox"/> 2000/4000 Aggregate <input type="checkbox"/> 2000/6000 <input type="checkbox"/> 3000/9000 <input type="checkbox"/> 2080-250 <input type="checkbox"/> 2080-500 <input type="checkbox"/> 2080-750 <input type="checkbox"/> 2080/1000		
SUPERMED PLUS HSA: <input type="checkbox"/> 1500/100 Aggregate <input type="checkbox"/> 2500/100 <input type="checkbox"/> 3000/100 <input type="checkbox"/> 4000/100 <input type="checkbox"/> 5000/100		
<input type="checkbox"/> SUPERMED PLUS HRA (additional Product Selection Sheet is required)		
SUPERMED CLASSIC GOLD: <input type="checkbox"/> 250/500 <input type="checkbox"/> 750/1500 <input type="checkbox"/> 500/1000 <input type="checkbox"/> 1000/2000		
<input type="checkbox"/> HMO Health Ohio (Prescription Drug Card Included)		
<input type="checkbox"/> MEDIFIL <input type="checkbox"/> MEDIFIL without Drug <input type="checkbox"/> MEDICARE Carve-Out		
<input type="checkbox"/> PRESCRIPTION DRUG CARD: <input type="checkbox"/> Option 1 <input type="checkbox"/> Option 2 <input type="checkbox"/> Option 3 <input type="checkbox"/> Option 4 (not available with 1000/2000, 2000/4000, Medifil or HSA plans)		
Is any part of the employee's or dependent's deductible being funded by the employer or from an employer-established account? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, how much? Single: _____ Family: _____		
Does the employer fund first? <input type="checkbox"/> Yes <input type="checkbox"/> No		

4. SuperDental Plans		Proposed Effective Date
<input type="checkbox"/> Basic PPO <input type="checkbox"/> Intermediate PPO <input type="checkbox"/> Advanced PPO		
<input type="checkbox"/> Alternative Advanced PPO <input type="checkbox"/> Alternative Basic PPO		

5. Vision Plans		Proposed Effective Date
VSP (Vision Service Plan)		
<input type="checkbox"/> Option 1 (100% employer contribution required) <input type="checkbox"/> Option 2 (25% – 75% employer contribution)		

6. Life and Disability Plans		Proposed Effective Date
Contributions:	Waiting Period (if different from medical)	
Life/AD&D <input type="checkbox"/> 100% <input type="checkbox"/> Other _____%	<input type="checkbox"/> None	
Voluntary Life <input type="checkbox"/> 100% <input type="checkbox"/> Other _____%	<input type="checkbox"/> First of the month following completion of _____ days	# of Employees Eligible _____
STD <input type="checkbox"/> 100% <input type="checkbox"/> Other _____%	<input type="checkbox"/> Other _____	# of Employees Enrolling _____
Voluntary STD <input type="checkbox"/> 100% <input type="checkbox"/> Other _____%	Waiting period applies to:	
Dependent Life <input type="checkbox"/> 100% <input type="checkbox"/> Other _____%	<input type="checkbox"/> All Employees <input type="checkbox"/> New Employees only	Rates are guaranteed for _____ months
Long Term Disability <input type="checkbox"/> 100% <input type="checkbox"/> Other _____%		

Schedule of Benefits

A. Class Definitions (if more than one class, definitions must be specific)

Class 1 _____
 Class 2 _____
 Class 3 _____
 Class 4 _____

Employees working less than _____ hours per week are not eligible for coverage unless otherwise noted above.

B. Selection of Coverage(s) (check all that apply and fill in all applicable blanks)

Class	<input type="checkbox"/> Basic Life Insurance Amount of Insurance	<input type="checkbox"/> Basic AD&D Principal Sum	<input type="checkbox"/> Short-Term Disability Weekly Maximum
1	_____	_____	_____
2	_____	_____	_____
3	_____	_____	_____

- Weekly STD benefit is subject to a maximum of _____% of employee's Basic Weekly Wage.
- STD Benefits Payable: _____ day of Accident; _____ day of Sickness for a maximum benefit period of _____ weeks.
- STD Benefits payable for non-occupational disabilities only.
- All benefits terminate at retirement unless otherwise noted in class definition section.
- STD Benefits not available for employees working in CA, HI, NJ, NY, PR or RI.
- Life or AD&D benefits include 24 hour coverage.
- If Life or AD&D benefits are based upon a multiple of salary, benefit amounts should be rounded to:
 - the next higher multiple of \$1,000
 - the nearest multiple of \$1,000
 - other _____
- Basic Life and AD&D benefits reduce by:
 - 50% at age 70; and further reduces to 25% of the face amount at age 75
 - _____% at age _____; and further reduces _____% of the face amount at age _____;
and further reduces to _____% of the face amount at age _____.
- Voluntary Life benefits terminate at retirement.

6. Life and Disability Plans (continued)

Group Long-Term Disability

*Employees must work a minimum of 30 hours per week

Select One Plan:

90 day elimination 180 day elimination Other _____

Dependent Life Insurance

Standard Option

Spouse: **\$ 5,000**

Child(ren): **\$ 0** Live birth but less than 14 days
\$ 100 Age 14 days but less than 6 months
\$ 5,000 Age 6 months but less than 21 years
\$ 5,000 Age 21 years but less than 25
(if full time student(s) and dependent upon the insured for support)

Other Option

Spouse: \$ _____
Child(ren): \$ _____ Live birth but less than 14 days
\$ _____ Age 14 days but less than 6 months
\$ _____ Age 6 months but less than _____ years
\$ _____ Age _____ years but less than _____
(if full time student(s) and dependent upon the insured for support)

Voluntary Life Insurance

Increments of \$10,000 to a maximum of \$300,000

Voluntary Short-Term Life Disability

Increments of \$50; minimum of \$100 to a maximum of \$500, not to exceed 70% of employee's Basic Weekly Wage.

Select One:

- Voluntary STD benefits payable: 1st day of Accident; 8th day of Sickness for a maximum benefit period of 26 weeks.
 Voluntary STD benefits payable: 15th day of Accident; 15th day of Sickness for a maximum benefit period of 26 weeks.

C. Non-Medical Maximum (amounts in excess of the amount stated are subject to satisfactory evidence of insurability)

Life: Basic \$ _____ Voluntary: \$ _____ Combined Basic and Voluntary: \$ _____
STD: \$ _____

D. Active Work

As of the proposed effective date, are any of your employees **not Actively at Work** (as defined below) **and, therefore, not eligible for coverage?**

Yes No If yes, please provide the following information: (Attach a signed dated sheet if more space is needed)

The terms "Actively at Work" and "Active Work" mean that an employee is performing the Material and Substantial Duties of his occupation; is working the number of hours specified in Part (6A), Schedule of Benefits; and satisfies any other conditions required by the applicable group Policy.

A. Name _____ Sex _____ Date of Birth _____ Date Last Worked _____

Reason not Actively at Work: Disability Family Leave Other _____

B. Name _____ Sex _____ Date of Birth _____ Date Last Worked _____

Reason not Actively at Work: Disability Family Leave Other _____

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.

Carrier Name	Continuing Coverage	Benefits*	Dates		Current Rates**				Renewal Rates**			
			From	To	Emplye	Spouse	Child	Family	Emplye	Spouse	Child	Family
	<input type="checkbox"/>											
	<input type="checkbox"/>											
	<input type="checkbox"/>											

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

8. Validations

Groups completing the Employer Risk Assessment Form may skip Sections A & B.
A. Serious Medical Conditions: As an employer are you aware of any employee or dependent of an employee, including those not enrolling for coverage, who has been diagnosed or treated for a serious health problem such as AIDS, HIV positive status, Alzheimer Disease, Cancer, Diabetes, Heart Attack or Heart Disease, Hemophilia, Kidney Disease, Mental Illness or Substance Abuse? Yes No If yes, provide details below. (Attach separate sheet of paper if needed)

Patient Name	Aggregate Dollar Amount of Claims	Dates of Service	Describe Illness or Condition

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	Describe Illness or Condition

C. Is anyone currently COBRA eligible/enrolled? Yes No If yes, provide details below.

Name	Social Security #	Beginning Date	Expiration Date	Qualifying Event

D. Are there any retirees who meet the eligibility requirements AND are members of a formal retirement program? Yes No If yes, provide details below.

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

9. 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 the carrier(s) offering the coverage indicated on this Application. I acknowledge that by applying for these products, coverage is provided by the following entities (collectively referred to as "Medical Mutual:")

- Medical Mutual of Ohio® (MMO) for non-HMO health plans
- Medical Health Insuring Corporation of Ohio (MHICO) for HMO health plans
- Consumers Life Insurance Company® (CLIC) for life, accidental death and dismemberment, and disability benefits.

I understand, acknowledge and agree to the following:

- This Employer Group Enrollment Application, Participation Agreement 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 contract(s) held by the Council of Smaller Enterprises (COSE), a division of Greater Cleveland Partnership (GCP). A copy of these policies is available at COSE's office for review. 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. For groups of 1-50 employees: Each employee applying for any product offered by Medical Mutual must complete **all** sections 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.
- 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.
- For life and/or disability coverage, I understand and agree: (1) COSE is not an insurer and has no obligations regarding payment of premium or handling of claims for the life and/or disability insurance provided under the group insurance policy issued to it as policyholder; and (2) upon acceptance and approval by Medical Mutual, I will, so long as such participation continues, fully comply with all obligations applicable to Participating Employers under the policy as set forth therein. I have relied upon no oral or written representations that contradict the aforementioned active-work information.

10. 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)