

**Medical, Dental and Vision  
EMPLOYEE  
APPLICATION and CHANGE FORM  
for individuals in  
Groups up to 19 Eligible**

**INSTRUCTIONS**

- **PRINT CLEARLY USING A BLUE OR BLACK PEN (NO HIGHLIGHTERS)**
- **NEW HIRES, LATE ENTRANTS AND DEPENDENT ADDITIONS MUST COMPLETE THE APPLICATION INCLUDING GROUP NUMBER AND MEDICAL HISTORY QUESTIONNAIRE.**
- **CHANGES TO AN EXISTING POLICY, COMPLETE ONLY AREA THAT IS CHANGING E.G.: DROPPING DEPENDENTS, ADDRESS CHANGES...**
- **IF ENROLLING A DEPENDENT/STUDENT, A STUDENT CERTIFICATION FORM MUST BE INCLUDED WITH THE APPLICATION.**
- **IF YOU DO NOT WANT ANY COVERAGE OR IF YOU REJECT SOME OF THE COVERAGE OPTIONS BUT ACCEPT OTHERS, COMPLETE THE WAIVER AREA.**

**WAIVER**

**A. Waived Coverages:** I do NOT want...(Check one)

- HEALTH through Consumers Life Insurance Company, a Medical Mutual of Ohio Company
- HEALTH through Consumers Life for the following dependents only: (Remember to complete the rest of this application)

1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_ 4) \_\_\_\_\_ 5) \_\_\_\_\_

**B. Current Health Coverage Status:** I have...(Check one)

- Coverage through my Spouse's Employer: \_\_\_\_\_  
Spouse's Company Name
- No coverage
- Other coverage: \_\_\_\_\_

**C. Authorization:** The terms of this waiver are explained below. I have read and understand these terms.

Company Name: \_\_\_\_\_

Print Employee Name: \_\_\_\_\_ Employee Social Security #: \_\_\_\_\_

Print Spouse Name: \_\_\_\_\_ Spouse Social Security #: \_\_\_\_\_

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

**THE EXPLANATION OF WAIVER**

I understand that if I check any box in Question A of the Waiver above that I am choosing not to have those persons covered under the health insurance designated and any later application for enrollment and acceptance will be subject to all underwriting requirements.

**If you are declining enrollment for yourself or your dependents (including your spouse) because of 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 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.**

# HEALTH APPLICATION / CHANGE

GROUP # \_\_\_\_\_ SECTION \_\_\_\_\_

## 1. (Please Print) ABOUT YOU AND YOUR JOB...

LAST NAME		SOCIAL SECURITY NUMBER		COMPANY NAME/EMPLOYER	
FIRST NAME	M.I.	DATE OF BIRTH / /	SEX (M or F)	OCCUPATION/JOB TITLE	EMPLOYEE/CLOCK #
STREET ADDRESS			DEPARTMENT NAME	DEPT. #	
CITY		STATE	ZIP CODE	FULL TIME DATE OF (RE)HIRE / /	EMPLOYMENT STATUS <input type="checkbox"/> ACTIVE <input type="checkbox"/> RETIRED <input type="checkbox"/> COBRA
HOME PHONE NUMBER ( ) -	MARITAL STATUS: <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED	BUSINESS PHONE ( ) - EXT.		COBRA EXPIRATION DATE / /	
EMAIL ADDRESS			EMAIL ADDRESS		

## 2. (Please Print) WHAT YOU WANT DONE...

<p style="text-align: center;"><b>A) NEW POLICY APPLICATION</b></p> <p>1. Type of Coverage: Check all that apply</p> <p><input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision</p> <p>2. Who Do You Want Covered? <input type="checkbox"/> You Only    <input type="checkbox"/> You and One Other Person    <input type="checkbox"/> You and Your Family</p>	<p style="text-align: center;"><b>B) CHANGE TO AN EXISTING POLICY</b></p> <p>1. Group # _____ Section # _____</p> <p>2. Date of Change: ____/____/____</p> <p>3. Action (Check the Type of Change)</p> <p><input type="checkbox"/> ADD DEPENDENT TO POLICY (LIST DEPENDENTS IN SECTION 3 BELOW)</p> <p><input type="checkbox"/> DELETE DEPENDENT FROM POLICY (LIST DELETED DEPENDENTS IN SECTION 3 BELOW)</p> <p><input type="checkbox"/> MARRIAGE: DATE MARRIED: _____</p> <p><input type="checkbox"/> NAME CHANGE: FORMER NAME: _____</p> <p><input type="checkbox"/> OTHER: _____</p>
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## 3. (Please Print) ABOUT YOU AND YOUR DEPENDENTS...

A.	(Add Change Delete)	First Name	Last Name	Social Security #	Date of Birth	Sex M or F	Relationship to you**
Spouse				- -	- -		
1				- -	- -		
2				- -	- -		
3				- -	- -		
4				- -	- -		
5				- -	- -		

\*\*Relationship to You: C = Child, SC = Stepchild, AC = Adopted child\*, O = Other\* (\*attach legal documentation)

## 4. (Please Print) ABOUT YOUR OTHER HEALTH INSURANCE AND MEDICARE...

What date did your most recent health insurance or health benefit program become effective  
(check box if no prior/current coverage)?    /    /     No Coverage

What date did/will the above health insurance or health benefit program terminate?    /    /

**DO YOU OR ANY OF YOUR DEPENDENTS HAVE ANY OTHER HEALTH OR DENTAL COVERAGE?**  YES  NO    **IF YES, COMPLETE THE SECTION BELOW.**

NAME OF POLICY HOLDER	NAME AND ADDRESS OF OTHER INSURANCE COMPANY	POLICY NUMBER	EFFECTIVE DATE	COVERAGE TYPES	WORK STATUS	POLICY TYPE
			/ /	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Hospital Only <input type="checkbox"/> Vision <input type="checkbox"/> Prescription Drug	<input type="checkbox"/> Active <input type="checkbox"/> Retired	<input type="checkbox"/> Single <input type="checkbox"/> Family
			/ /	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Hospital Only <input type="checkbox"/> Vision <input type="checkbox"/> Prescription Drug	<input type="checkbox"/> Active <input type="checkbox"/> Retired	<input type="checkbox"/> Single <input type="checkbox"/> Family

**MEDICARE INFORMATION:**     YES     NO    If YES, Medicare No. \_\_\_\_\_

Are you covered by Medicare?

Is your spouse or dependent covered by Medicare?     YES     NO    If YES, Medicare No. \_\_\_\_\_

EFFECTIVE DATE: PART A:    /    /

PART B:    /    /

Hemodialysis

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EFFECTIVE DATE: PART A:    /    /

PART B:    /    /

Hemodialysis

**MEDICAL HISTORY QUESTIONNAIRE (For Groups with up to 19 eligible employees)**

<b>5.</b> Applicant (Full Name)			Social Security Number	Group Number	Height	Weight
Dependents (Full Name)			Height	Weight	Dependents (Full Name)	
Spouse						
1			4			
2			5			
3			6			

**5A. Check all medical conditions, diseases listed below for which you or any of your dependents have, within the past 10 years, been medically diagnosed or medically treated: (Use number and letter to identify conditions in 5C)**

<input type="checkbox"/> 1. Transplant (any organ)	<input type="checkbox"/> 19. Other Lung Disorders	<input type="checkbox"/> 36. Bypass Surgery
<input type="checkbox"/> 2. Connective Tissue Disease	<input type="checkbox"/> 20. Liver Disorders	<input type="checkbox"/> 37. Congestive Heart Failure
<input type="checkbox"/> 3. A.I.D.S./A.R.C./H.I.V.	<input type="checkbox"/> 21. Congenital Disease/Defect	<input type="checkbox"/> 38. Pacemaker
<input type="checkbox"/> 4. Arthritis, Osteo	<input type="checkbox"/> 22. Paralysis	<input type="checkbox"/> 39. Ischemic Heart Disease
<input type="checkbox"/> 5. Arthritis, Rheumatoid	<input type="checkbox"/> 23. Multiple Sclerosis	<input type="checkbox"/> 40. Other Heart Disorders
<input type="checkbox"/> 6. Back/Spinal Disorder	<input type="checkbox"/> 24. Cerebral Palsy	<input type="checkbox"/> 41. High Blood Pressure Yes, Give Last 3 Blood Pressures & Dates A. B. C.
<input type="checkbox"/> 7. Scoliosis	<input type="checkbox"/> 25. Epilepsy	<input type="checkbox"/> 42. Alcohol or Drug Dependency
<input type="checkbox"/> 8. Spina Bifida	<input type="checkbox"/> 26. Parkinson's	<input type="checkbox"/> 43. Attempted Suicide
<input type="checkbox"/> 9. Ulcerative Colitis	<input type="checkbox"/> 27. Alzheimer's Disease	<input type="checkbox"/> 44. Anorexia/Bulimia
<input type="checkbox"/> 10. Diverticulitis	<input type="checkbox"/> 28. Other Neurological Disorders	<input type="checkbox"/> 45. Chronic Depression
<input type="checkbox"/> 11. Crohn's Disease	<input type="checkbox"/> 29. Hemophilia	<input type="checkbox"/> 46. Other Mental/Emotional Disorders
<input type="checkbox"/> 12. Gastric/Peptic Ulcer	<input type="checkbox"/> 30. Kidney/Urinary Disorders	<input type="checkbox"/> 47. Venereal Disease
<input type="checkbox"/> 13. Other Bowel/Stomach Disorders	<input type="checkbox"/> 31. Tumors/Growths	<input type="checkbox"/> 48. Deafness
<input type="checkbox"/> 14. Stroke (Date)	<input type="checkbox"/> 32. Juvenile Diabetes	<input type="checkbox"/> 49. Currently Pregnant If so, state expected date / /
<input type="checkbox"/> 15. Cancer, Leukemia or Melanoma	<input type="checkbox"/> 33. Diabetes Mellitus Yes, Give Last 3 Blood Sugars & Dates A. B. C.	<input type="checkbox"/> 50. Hepatitis
<input type="checkbox"/> 16. Emphysema	<input type="checkbox"/> 34. Heart Attack/M.I.	
<input type="checkbox"/> 17. Chronic Bronchitis	<input type="checkbox"/> 35. Coronary Artery Disease	
<input type="checkbox"/> 18. Asthma		

**5B. MEDICAL QUESTIONS**

- 1) Within the past 10 years, have you or your dependents had, been medically treated for, or medically diagnosed with any other condition/disorder/disease not listed above? If yes, explain in 5C. Yes  No
- 2) In the past 10 years, have you or your dependents been hospitalized, operated on or been medically advised to have an operation which has not yet been performed? If yes, explain in 5C.
- 3) Have you or any dependent listed been treated on an outpatient basis: Testing, Rehabilitation, Home Health Care or Emergency Room within the last two years? If yes, explain in 5C.
- 4) Within the past 10 years, have you or your dependents been on Fertility Drugs, had a High Risk Pregnancy, Abnormal Pap Test, or a Venereal Disease? If yes, explain in 5C.
- 5) Are you or any of your dependents currently taking any prescription medications? If Yes, indicate medication, reason for taking and dosage per day in Section 5C.
- 6) Do any of the conditions identified above involve Worker's Compensation? If Yes, provide the Worker's Compensation Case Number: #: \_\_\_\_\_
- 7) Have you or your dependents ever been restricted from, or declined for coverage by any carrier? If yes, explain in 5C.

**5C. EXPLANATION**

Condition/Question #	Individual (FULL NAME)	Physician's Name and Address	Treatment Dates (FROM /TO)	Diagnosis, Treatment, Prognosis, Medication, Dosage and Reason (be specific)

Attach a separate sheet in this format if more space is required.

**6. THE TERMS AND WHAT YOU DECLARE**

**I hereby apply to Consumers Life Insurance Company for the coverage indicated on this application.**

- \* I authorize: (1) payroll deduction(s) and remittance of any required contribution for coverage to Consumers Life and or any administrator designated by Consumers Life ; (2) release of information, without limitation, from any medical/medically-related facility, government agency or person: (a) to evaluate this application for up to 30 months from the date of this application; (b) to adjudicate claims submitted on behalf of me or my dependents as long as I am covered under this policy; (c) for utilization review programs to monitor health services or quality improvement activities; (d) for credentialing purposes. I authorize the applicable carrier to provide a photocopy of this release to any physician or medical institution to obtain records for the purposes stated above.
- \* I understand: (1) any untrue or incomplete information, statements or answers on this application (whether intentional or not), can result in denial of a claim and may subject me to legal action by Consumers Life; (2) to be eligible for health coverage, I must be an active full-time employee, as defined by my employer; (3) if coverage is issued, it will be based on full reliance on the information contained in this application;
- \* I understand: and agree that no agent or broker has the authority: (1) to bind Consumers Life by making promises regarding eligibility, benefits, or the issuance of a policy; (2) to waive any answer or any portion of any answer to any question on this application or any information Consumers Life requests; (3) approve coverage; (4) make or alter any contract on behalf of Consumers Life; or (5) waive or alter any of Consumers Life Insurance Company's other rights or requirements. All contract terms must be in writing and signed or accepted in writing by an authorized representative of Consumers Life to be binding on Consumers Life.

**7. SIGNATURES - Sign after completing and reading all applicable sections.**

I have read all of the statements contained in this application, and declare by signing this application that I am an active, eligible, compensated, full-time employee and that the information I have provided is true and complete to the best of my knowledge. Signature of Spouse authorizes release of information described on the front of this application.

\_\_\_\_\_  
Your Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Your Spouse's Signature (if applying for dependent coverage)

\_\_\_\_\_  
Date

**WARNINGS:** Any person who, with intent to defraud or knowing that he or she 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.

If you or your family members are covered by more than one health care plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and hospitals, and it may be impossible to comply with both plans at the same time. Before you enroll in this plan, read all of the rules very carefully and compare them with the rules of any other plan that covers you or your family.