

Medical, Dental and Vision EMPLOYER/GROUP ENROLLMENT APPLICATION

THIS IS AN APPLICATION FOR COVERAGE, NOT A CONTRACT.
DO NOT CANCEL YOUR CURRENT COVERAGE UNTIL YOU HAVE RECEIVED WRITTEN ACCEPTANCE FROM
CONSUMERS LIFE INSURANCE COMPANY, A MEDICAL MUTUAL OF OHIO® COMPANY.

NOTE: If your group is accepted, Consumers Life cannot provide retroactive effective dates.

| 1. GROUP/COMPANY INFORMATION | | | |
|---|--|---|----------|
| GROUP NAME | | EIN/FEDERAL TAX ID # | |
| HAS THIS GROUP EVER BEEN KNOWN BY ANOTHER NAME? <input type="checkbox"/> YES <input type="checkbox"/> NO | | IF YES, WHAT NAME(S). DUN & BRADSTREET # | |
| ADDRESS | | EMAIL ADDRESS | |
| BILLING ADDRESS, IF DIFFERENT THAN GROUP LOCATION | | | |
| CITY | COUNTY | STATE | ZIP CODE |
| PHONE NUMBER | | Ext. | |
| CHIEF EXECUTIVE | | BILLING CONTACT | |
| RENEWAL CONTACT | | SIC CODE | |
| TYPE OF BUSINESS (be specific) | | HAS THIS GROUP EVER APPLIED TO CONSUMERS LIFE BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| WHEN? | | YEARS IN BUSINESS | |
| PROPOSED EFFECTIVE DATE FOR COVERAGE TO START: / / | | | |
| 2. ENROLLMENT CRITERIA | | | |
| ELIGIBLE EMPLOYEE PROFILE | Minimum # of Hours Worked per week to be considered eligible for Health Care Benefits _____ (Minimum must be between 20 and 40 hours for groups with 50, or less eligible employees.) | Probation Period for Health Care Benefits <input type="checkbox"/> Date of Hire <input type="checkbox"/> 30 days following Date of Hire <input type="checkbox"/> 60 days following Date of Hire <input type="checkbox"/> 90 days following Date of Hire <input type="checkbox"/> 180 days following Date of Hire <input type="checkbox"/> First of month following Date of Hire <input type="checkbox"/> First of month following 30 days <input type="checkbox"/> First of month following 60 days <input type="checkbox"/> First of month following 90 days | |
| Waive probation period for initial enrollment? <input type="checkbox"/> YES <input type="checkbox"/> NO | | Probation Period for Rehires <input type="checkbox"/> Same as above <input type="checkbox"/> Others | |
| 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. | | | |
| PARTICIPATION | Active* | COBRA | Retired* |
| Total Number of Current Employees (part time & full time) | | | |
| Total Number of Eligible Employees | | | |
| Number of Employees Applying for Coverage | | | |
| * Including Owners, Officers and Partners who receive compensation from the company, reported on a tax form other than a 1099. | | | |

CONSUMERS LIFE GROUP #

3. STANDARD BENEFIT OPTIONS - (check appropriate box(es))

| GROUP SIZE ENROLLING | BENEFIT PROGRAMS | |
|----------------------|---|---|
| 2+ | Medical Plans <input type="checkbox"/> 25100-0 <input type="checkbox"/> 2580-500 <input type="checkbox"/> 25100-500 <input type="checkbox"/> 3080-1000 <input type="checkbox"/> 30100-1000 <input type="checkbox"/> 30100-1500 <input type="checkbox"/> 2590-250 <input type="checkbox"/> 2590-500 <input type="checkbox"/> 3090-1000 <input type="checkbox"/> 2580-250 <input type="checkbox"/> Medical Plans _____ and _____ | High Deductible Plan Options <input type="checkbox"/> SMP 2200 <input type="checkbox"/> SMP 2500 <input type="checkbox"/> SMP 3000 <input type="checkbox"/> SMP 4000 <input type="checkbox"/> SMP 5000 |
| | 2+ | <input type="checkbox"/> Vision |
| 2+ | <input type="checkbox"/> Dental | |
| 2+ | <input type="checkbox"/> Medicare Carveout (Available with Medical and High Deductible Health Plan Options Only) | |

4. CURRENT and PRIOR CARRIER HISTORY (If more space is needed, attach an additional sheet in the same format.)

List all carriers used for all product lines offered to the employees for the past 5 years. If there are no carriers, indicate NONE.

| CARRIER NAME (Current Carrier First) | CHECK IF CONTINUING COVERAGE | TYPE OF PLAN* | TYPE OF BENEFIT** | DATES | | CURRENT RATES | | | | RENEWAL RATES*** | | | |
|---|------------------------------|---------------|-------------------|-------|----|---------------|----------|--------|----------|------------------|----------|--------|----------|
| | | | | From | To | Single | 2-Person | Family | Medicare | Single | 2-Person | Family | Medicare |
| 1. | <input type="checkbox"/> | | | | | | | | | | | | |
| 2. | <input type="checkbox"/> | | | | | | | | | | | | |
| 3. | <input type="checkbox"/> | | | | | | | | | | | | |

* Examples: Traditional, HMO, PPO, etc... **Examples: Comp. Major Med., 1st Dollar, etc... *** For the current carrier and any continuing coverage.

5. VALIDATIONS (If more space is needed, attach an additional sheet in the same format.)

Groups completing the Employer Risk Assessment Form may skip 5A and B.

A • SERIOUS MEDICAL CONDITIONS: As an employer are you aware of any employee or dependent of an employee, including those not enrolling in Consumers Life coverage, who has been medically diagnosed or medically treated for a serious health problem such as AIDS, HIV Positive Status, Alzheimer's Disease, Cancer, Diabetes, Heart Attack or Heart Disease, Hemophilia, Kidney Disease, Mental Illness or Substance Abuse? YES NO If Yes, provide details below.

| PATIENT NAME | DATE OF BIRTH | RELATIONSHIP TO EMPLOYEE | AGGREGATE DOLLAR AMOUNT OF CLAIMS | DATES OF SERVICE | DESCRIBE ILLNESS OR CONDITION (include Worker's Compensation #) |
|--------------|---------------|--------------------------|-----------------------------------|------------------|---|
| | | | | | |
| | | | | | |
| | | | | | |

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 | DOB | REL. TO EMP. | DESCRIBE ILLNESS OR CONDITION (include Workers Compensation #) |
|--------------|-----|--------------|--|
| | | | |
| | | | |

C • IS ANYONE CURRENTLY COBRA Eligible/Enrolled? YES NO If Yes, provide details below.

| NAME | SOCIAL SECURITY # | DATE OF QUALIFYING EVENT | EXPIRATION DATE | QUALIFYING EVENT |
|------|-------------------|--------------------------|-----------------|------------------|
| | | | | |
| | | | | |

D • ARE THERE ANY RETIREES who meet the eligibility requirements? YES NO If Yes, provide details below.

| NAME | SOCIAL SECURITY # | AGE AT RETIREMENT | DATE OF RETIREMENT | DATE OF HIRE | AVG. HRS. WORKED PER WEEK PRIOR TO RETIREMENT |
|------|-------------------|-------------------|--------------------|--------------|---|
| | | | | | |
| | | | | | |

6. TERMS AND CONDITIONS

1. The group named herein, hereby applies to Consumers Life Insurance Company, a Medical Mutual of Ohio Company for the benefits selected herein. The group understands and acknowledges that the actual benefits will be specified in the group contract if this application is accepted by Consumers Life and that benefits will take effect as of the date specified in such group contract. **This Employer/Group Enrollment Application is not a contract for health care benefits. Continue your current coverage until you are notified, in writing, that Consumers Life has accepted this application.**
2. For all groups: Each employee not enrolling must complete the Waiver on the cover page of the Employee Application, Change Form and Medical History Questionnaire. For groups with 2 - 50 members: Each employee enrolling must complete all sections of the Employee Application, Change Form and Medical History Questionnaire (Sections 1 - 8).
3. To be eligible for coverage, an individual must be a full time employee of the group or company applying for coverage. Any individual who applies for insurance coverage from Consumers Life must be a full-time common law employee, drawing a regular paycheck and with compensation reported on IRS Form W-2. Independent contractors of the group or company are not eligible for coverage.
4. To be eligible for coverage by Consumers Life the group or company must be in compliance with all applicable state and federal laws.
5. Any untrue or incomplete information, statements or answers on this application (whether intentional or not) or engaging in any fraudulent conduct, deception or misrepresentation relating to any application, coverage, claim or usage of a Consumers Life identification card can result in denial of a claim or rescission of coverage for the group or any group member and may subject the group or any group member to legal action by Consumers Life.
6. Approval and rating of this Employer/Group Enrollment Application is subject to Consumers Life underwriting guidelines, including contribution and participation requirements.
7. It is agreed that this Employer/Group Enrollment Application supersedes any previous applications for this group coverage.
8. By signing this Employer/Group Enrollment Application, the authorized representative of the group or company represents that the group or company is not an entity that has been formed primarily to obtain health insurance coverage, and it does not permit membership in the group or company solely for the purpose of obtaining health insurance coverage.
9. The group hereby authorizes Consumers Life to obtain information from prior carriers to determine existence of pre-existing conditions. Prior carriers are authorized to release such information to Consumers Life upon receipt of a copy of this application.
10. I understand and agree that no agent or broker has the authority: (i) to bind Consumers Life by making promises regarding eligibility, benefits, or the issuance of a policy; (ii) to waive any answer or any portion of any answer to any question on this application or any information Consumers Life requests; (iii) approve coverage; (iv) make or alter any contract on behalf of Consumers Life; or (v) 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. AUTHORIZED SIGNATURE

| | |
|---|------|
| PRINT NAME and TITLE of the authorized representative who has full power and authority to legally bind and act on behalf of the group. | |
| SIGNATURE of the AUTHORIZED REPRESENTATIVE I certify that I understand the contents of this application and that the information stated herein is true and correct and that I will promptly notify Consumers Life of any changes. | DATE |

8. BROKER INFORMATION

| | | |
|-----------------------|----------------|---------------|
| BROKER (PLEASE PRINT) | TAX ID/SSN | BDS SALES REP |
| BROKER SIGNATURE | BROKER ADDRESS | |

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such persons to criminal and civil penalties.