



MMO USE ONLY
EFFECTIVE DATE: ____ / ____ / ____
GROUP NUMBER: _____

HEALTH APPLICATION/CHANGE FORM – OHIO

INSTRUCTIONS: All questions must be answered. Incomplete applications will be returned.

Section I: Contract Holder Information

Last Name		MI	First Name		SS Number
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed			Marriage Date: / /		Divorce Date: / /
Permanent Residence			City		E-mail Address
County	State	Zip Code	Phone Number ()		Occupation
Reason for Application: <input type="checkbox"/> Applying for new coverage <input type="checkbox"/> Applying for dependent only coverage <input type="checkbox"/> Applying for change to current coverage					

LIST BELOW ALL INDIVIDUALS TO BE COVERED

	First Name, MI (and last name, if different)	Social Security Number	Birth Date	Sex	Height	Weight	Tobacco User	Student
Self							Y N	
Spouse							Y N	
1							Y N	Y N
2							Y N	Y N
3							Y N	Y N

Section II: Federal and Ohio Open Enrollment Eligibility

1. Yes No Are you a **Federally Eligible Individual** or applying for coverage under the **Ohio Open Enrollment** requirements?

If Yes, **STOP HERE.** SuperMed One® is NOT a Federally Eligible or Ohio Open Enrollment product. For an information and application packet, please call Medical Mutual at 800/242-1936. SuperMed One may affect your status as a federally eligible individual. Visit the ohioinsurance.gov Web site for more information.

Section III: Products

<p>SuperMed One Standard Plans: <i>Deductible Single/Family</i></p> <p><input type="checkbox"/> \$500/\$1,000 <input type="checkbox"/> \$2,500/\$5,000</p> <p><input type="checkbox"/> \$1,000/\$2,000 <input type="checkbox"/> \$5,000/\$10,000</p> <p><input type="checkbox"/> \$1,500/\$3,000</p> <p>Available Riders:</p> <p><input type="checkbox"/> Prescription Drug Copay (\$15/\$30/\$45)</p> <p><input type="checkbox"/> Maternity Services</p>	<p>SuperMed One HSA Plans: <i>Deductible Single/Family</i></p> <p><input type="checkbox"/> \$1,200/\$2,400</p> <p><input type="checkbox"/> \$2,200/\$4,400</p> <p><input type="checkbox"/> \$2,500/\$5,000</p> <p><input type="checkbox"/> \$3,000/\$6,000</p> <p><input type="checkbox"/> \$4,000/\$8,000</p> <p><input type="checkbox"/> \$5,000/\$10,000</p>	<p>SuperMed One Value Plans: <i>Deductible Single/Family</i></p> <p><input type="checkbox"/> \$500/\$1,000</p> <p><input type="checkbox"/> \$1,000/\$2,000</p> <p><input type="checkbox"/> \$1,500/\$3,000</p> <p>SuperMed One Short Term: <i>Deductible Single/Family</i></p> <p><input type="checkbox"/> \$500/\$1,000</p>
<p>Optional Coverage¹:</p> <p><input type="checkbox"/> Dental <input type="checkbox"/> Vision</p>		
<p>Desired effective date: _____ / _____ / _____ (when coverage is to begin)</p>		

¹Dental and Vision coverage can be purchased as a stand-alone product. One year of premium is due when purchased as a stand-alone product.

Section IV: OTHER COVERAGE INFORMATION

1. Yes No Does **ANY PERSON TO BE COVERED** have any other type of health insurance (Accident, Medicare, Medicaid, etc.) or is **ANY PERSON TO BE COVERED** currently applying for any other health insurance? If yes, please complete the following:

NAME	TYPE	NAME OF INSURANCE COMPANY

2. Yes No Has **ANY PERSON TO BE COVERED** been insured by another health plan within the last 63 days? If yes, please complete the following:

NAME	NAME OF INSURANCE COMPANY	DATES OF COVERAGE	
		From:	To:
		From:	To:
		From:	To:
		From:	To:
		From:	To:

Section V: MEDICAL ELIGIBILITY

IMPORTANT: SuperMed One is a medically underwritten product. Please answer all medical eligibility questions completely. Use additional paper, if necessary. Incomplete applications will be returned.

A. Yes No Are **YOU**, your **SPOUSE** or any **DEPENDENT** currently pregnant, an expectant parent, or in the process of adoption (**even if not named on this application**)?

Name	Due Date
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B. Yes No Has **ANY PERSON TO BE COVERED** taken any prescription medication, or been prescribed medication by a physician, during the past 12 months?

NAME	MEDICATION AND DOSAGE	MEDICAL CONDITION

C. Yes No Has any insurance company refused, restricted or charged more than a standard rate for health coverage on **ANY PERSON TO BE COVERED**?

NAME	REFUSAL OR RESTRICTION	MEDICAL CONDITION

Section V: MEDICAL ELIGIBILITY (continued)

D. Yes No Does **ANY PERSON TO BE COVERED** have a condition covered by Workers' Compensation?

NAME	WORKERS' COMPENSATION NUMBER	MEDICAL CONDITION

E. Yes No In the past twelve months, has **ANY PERSON TO BE COVERED** had any of the following symptoms: unexplained weight loss, night sweats, persistent fever or cough, malaise, prolonged fatigue, chronic/recurrent skin rashes or lesions, recurrent episodes of diarrhea, lymph node enlargement, unexplained recurrent headache, or unexplained pain or discomfort?

NAME	SYMPTOMS	DATES

F. Yes No In the past twelve months, has surgery, diagnostic testing or medical treatment been recommended or considered for any person to be covered?

NAME	DATE	REASON	RESULTS

G. For each person to be covered, provide the name of their physician, and the last time they saw their physician:

NAME	PHYSICIAN NAME	DATE	REASON	RESULTS

Section V: MEDICAL ELIGIBILITY (continued)

H. Has **ANY PERSON TO BE COVERED** within the past ten years been treated for, diagnosed as having, hospitalized, had surgery, been recommended for future surgery, diagnostic testing or medical treatment or thought you should seek medical advice for any of the following conditions? Each condition must be checked (✓) yes or no.

CONDITION	YES	NO	CONDITION	YES	NO	CONDITION	YES	NO
1. Abnormal Pap Smears	<input type="checkbox"/>	<input type="checkbox"/>	34. Down's Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	64. Mental Health Disorders	<input type="checkbox"/>	<input type="checkbox"/>
2. AIDS, ARC, or HIV	<input type="checkbox"/>	<input type="checkbox"/>	35. Drug/Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	(Including Depression, Anxiety,	<input type="checkbox"/>	<input type="checkbox"/>
3. Allergies	<input type="checkbox"/>	<input type="checkbox"/>	(Including Arrests/Convictions)			ADD/ADHD and counseling)	<input type="checkbox"/>	<input type="checkbox"/>
4. Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>	36. Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>	65. Migraines	<input type="checkbox"/>	<input type="checkbox"/>
5. Anemia (Type: _____)	<input type="checkbox"/>	<input type="checkbox"/>	37. Fibrocystic Breast Disease	<input type="checkbox"/>	<input type="checkbox"/>	66. Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
6. Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	38. Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	67. Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>
7. Anorexia/Bulimia	<input type="checkbox"/>	<input type="checkbox"/>	39. Gallbladder Disease	<input type="checkbox"/>	<input type="checkbox"/>	68. Organ Transplant/Failure	<input type="checkbox"/>	<input type="checkbox"/>
8. Arthritis (Type: _____)	<input type="checkbox"/>	<input type="checkbox"/>	40. Gastric Reflux (GERD)	<input type="checkbox"/>	<input type="checkbox"/>	69. Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
9. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	41. Gastric Bypass / Banding	<input type="checkbox"/>	<input type="checkbox"/>	70. Otitis Media (ear infections)	<input type="checkbox"/>	<input type="checkbox"/>
10. Back Sprains/Strains	<input type="checkbox"/>	<input type="checkbox"/>	42. Gout	<input type="checkbox"/>	<input type="checkbox"/>	71. Ovarian Cyst/Polycystic	<input type="checkbox"/>	<input type="checkbox"/>
11. Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	43. Graves Disease	<input type="checkbox"/>	<input type="checkbox"/>	Ovarian Disease		
12. Bursitis	<input type="checkbox"/>	<input type="checkbox"/>	44. Growth Deficiency	<input type="checkbox"/>	<input type="checkbox"/>	72. Pacemaker Implantation	<input type="checkbox"/>	<input type="checkbox"/>
13. Cancer (Type: _____)	<input type="checkbox"/>	<input type="checkbox"/>	45. Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	73. Pancreatitis	<input type="checkbox"/>	<input type="checkbox"/>
14. Cardiomyopathy	<input type="checkbox"/>	<input type="checkbox"/>	46. Heart Bypass Grafting	<input type="checkbox"/>	<input type="checkbox"/>	74. Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
15. Carotid Artery Disease	<input type="checkbox"/>	<input type="checkbox"/>	47. Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	75. Parkinson's Disease	<input type="checkbox"/>	<input type="checkbox"/>
16. Carpel Tunnel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	48. Heart Palpitations/Arrhythmia	<input type="checkbox"/>	<input type="checkbox"/>	76. Peptic/Gastric Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
17. Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	49. Heart Valve Disorders	<input type="checkbox"/>	<input type="checkbox"/>	77. Peripheral Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>
18. Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	50. Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	78. Phlebitis/Blood Clot	<input type="checkbox"/>	<input type="checkbox"/>
19. Cholesterol (High)	<input type="checkbox"/>	<input type="checkbox"/>	51. Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	79. Polycystic Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
20. COPD or Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	52. Hydrocephalus/Shunt	<input type="checkbox"/>	<input type="checkbox"/>	80. Prostate Disorders	<input type="checkbox"/>	<input type="checkbox"/>
21. Cirrhosis of the Liver	<input type="checkbox"/>	<input type="checkbox"/>	53. Hypertension (High Blood	<input type="checkbox"/>	<input type="checkbox"/>	81. Schizophrenia/Bipolar	<input type="checkbox"/>	<input type="checkbox"/>
22. Colitis (Including Ulcerative)	<input type="checkbox"/>	<input type="checkbox"/>	Pressure)			82. Scleroderma	<input type="checkbox"/>	<input type="checkbox"/>
23. Colon Polyps	<input type="checkbox"/>	<input type="checkbox"/>	Last 3 Pressures & Dates:			83. Seizure Disorder/Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
24. Congenital Disorders	<input type="checkbox"/>	<input type="checkbox"/>	1) _____			84. Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>
25. Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	2) _____			85. Skin Conditions (includes Acne,	<input type="checkbox"/>	<input type="checkbox"/>
26. Coronary Artery Disease	<input type="checkbox"/>	<input type="checkbox"/>	3) _____			Psoriasis, Rosacea, Nail Fungus)	<input type="checkbox"/>	<input type="checkbox"/>
(Including Angina and			54. Ileostomy/Colostomy	<input type="checkbox"/>	<input type="checkbox"/>	86. Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>
Angioplasty)			55. Infertility	<input type="checkbox"/>	<input type="checkbox"/>	87. Spina Bifida Cystica/Occulta	<input type="checkbox"/>	<input type="checkbox"/>
27. Coronary Insufficiency	<input type="checkbox"/>	<input type="checkbox"/>	56. Irritable Bowel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	88. Spinal Disorders/Disc Disease	<input type="checkbox"/>	<input type="checkbox"/>
28. Crohns Disease	<input type="checkbox"/>	<input type="checkbox"/>	57. Joint Replacement	<input type="checkbox"/>	<input type="checkbox"/>	89. Stroke	<input type="checkbox"/>	<input type="checkbox"/>
29. Cystic Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	58. Kidney Failure	<input type="checkbox"/>	<input type="checkbox"/>	90. Suicide Attempts/Psych Admits	<input type="checkbox"/>	<input type="checkbox"/>
30. Cystitis (Chronic or interstitial)	<input type="checkbox"/>	<input type="checkbox"/>	59. Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	91. Systemic Lupus	<input type="checkbox"/>	<input type="checkbox"/>
31. Cysts, Tumors or Growths	<input type="checkbox"/>	<input type="checkbox"/>	60. Liver Disorders/Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	92. Tendonitis	<input type="checkbox"/>	<input type="checkbox"/>
32. Diabetes/Blood Sugar Disorder	<input type="checkbox"/>	<input type="checkbox"/>	61. Lou Gehrig's Disease (ALS)	<input type="checkbox"/>	<input type="checkbox"/>	93. Thyroid Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Last 3 Blood Sugars & Dates:			62. Meningitis	<input type="checkbox"/>	<input type="checkbox"/>	94. TMJ	<input type="checkbox"/>	<input type="checkbox"/>
1) _____			63. Menstrual Disorders (including	<input type="checkbox"/>	<input type="checkbox"/>	95. Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>
2) _____			Abnormal Cycles/Uterine			96. Transient Ischemic Attacks	<input type="checkbox"/>	<input type="checkbox"/>
3) _____			Bleeding)			(TIA)		
33. Diverticulitis/Diverticulosis	<input type="checkbox"/>	<input type="checkbox"/>				97. Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>
						98. Other condition(s) not listed	<input type="checkbox"/>	<input type="checkbox"/>

I. Yes No In the past ten years, has **ANY PERSON TO BE COVERED** been treated, diagnosed, or consulted a physician, psychotherapist, counselor, or any other provider, for any illness, injury, medical abnormality or mental or emotional condition not stated in questions A-H?

Section VI: BILLING INFORMATION

CHOOSE ONE:

HOME — Receive monthly premium billings

FINANCIAL INSTITUTION — Have monthly automatic premium withdrawals

If you wish to be billed through your financial institution, please complete the following authorization:

I authorize Medical Mutual of Ohio to initiate premium deductions from my account. The authorization will remain in effect until Medical Mutual of Ohio and my financial institution have received written notification from me within a reasonable time period to allow termination of the deduction.

Premiums are to be deducted from: Checking Savings
(Please note: Not all Financial Institutions allow deductions from a savings account. Please verify this information with your financial institution.)

Name and branch of bank/financial institution (must be in Ohio)			Account Number
Address			Account Holder's Name
City	State	Zip	Transit Routing Number
Account Holder's Signature			Date

Please attach a voided check for checking account or a deposit slip for savings account in order for our office to verify the bank information.

CREDIT CARD — Have monthly premium billed to credit card

If you wish to be billed through your credit card, please complete the following authorization: Mastercard Visa

Cardholder Name	Card Number
Bank Name (if applicable)	Expiration Date
Account Holder's Signature	Date

LIST BILLING THROUGH EMPLOYER — is available only to employees of a common employer who has agreed to collect the premiums on a monthly basis through payroll deduction and where the employer is not paying any portion of the premium.

Name of Employer	Occupation	
Address	Phone Number	
City	State	Zip Code

DIFFERENT BILLING ADDRESS Have home billing sent to a different address

If your mailing address is different than your permanent address, complete the following:

Last Name (C/O)	First Name	MI
Address		
City	State	Zip

ATTACH VOIDED CHECK
OR DEPOSIT SLIP HERE

FOR OFFICE USE ONLY

Sold — Account Executive and Code
Service — Account Executive and Code

or

Agent of Record	Tax I.D.
Royal Advantage® Broker	Commission Indicator

Section VII: TERMS AND CONDITIONS

I hereby apply under Medical Mutual of Ohio's Group Trust for the coverage indicated on this application. I further agree to participate in such trust and agree to be bound to the relevant terms of the Master Group Contract(s) and the Trust Agreement.

1. I authorize release of information, without limitation, from any medical/medically related facility, prior health insurance carrier, the Medical Information Bureau, Inc. (MIB), government agency or person to Medical Mutual of Ohio (MMO) and/or any affiliates or division of MMO: (a) to evaluate this application; (b) to adjudicate claims submitted on behalf of me or my dependents; (c) for utilization review programs to monitor health services or quality improvement activities and/or; (d) for credentialing purposes. I authorize MMO to provide a photocopy of this release to any physician or medical institution to obtain records for the purposes stated above. This authorization will be valid for a period of two and one-half years for the purpose of collecting information regarding this Application.
2. I agree that a medical examination of me may be required in connection with this Health Insurance Application. I further agree that I, as the Applicant, will be responsible to pay for the medical examination and/or the release of any and all records on behalf of myself, my spouse, and/or the listed dependents.
3. By signing below, I represent and warrant as follows: (a) I have thoroughly read and understand this Health Application and the questions asked herein; (b) I have answered each and every question set forth in this Application; (c) all of my answers to each of the questions are accurate, complete and true and (d) I did not sign a blank or partially completed Application. I agree that MMO, in their sole discretion, may rescind my policy at any time on the basis of any untrue, inaccurate or incomplete answer to any question in this Application, or any misrepresentation, omission or concealment on this Application, whether intentional or otherwise. I further agree that if a policy is issued, it will be issued by MMO in full reliance and in consideration of the information, answers and statements contained herein. I understand that this policy will be medically underwritten.
4. I have read the sales materials and understand the plan benefits, exclusions, and limitations as outlined therein. I acknowledge that the managed care features of this health insurance policy (such as the preferred provider organization network) have been explained to my satisfaction. I also understand that I may review a copy of the Master Group Contract(s) and Trust Agreement upon making such a written request to MMO.
5. No issuance, waiver, modification or change of policy or any of MMO rules or amendments shall be binding upon MMO unless it is in writing and signed by an authorized officer of MMO, as applicable.
6. Notice: Certain Pre-Existing Condition limitations will apply.
7. I represent that neither I nor my spouse are receiving any form of reimbursement or compensation for this coverage from any employer.
8. I also understand that information submitted with this application may require further medical underwriting. If that underwriting discloses additional medical risk I understand that there may be a significant change in the rate charged for this coverage or in certain cases, the coverage may be rescinded. A permanent ID card will be issued following the final review and acceptance of the application.
9. I understand and agree that I am solely and exclusively responsible for the truth, accuracy and completeness of all of the answers contained in this application. I understand and agree that no agent or broker who may be assisting in the completion of this application has any authority (a) to waive any answer or any portion of any answer to any question on this application or any information MMO requests, (b) to advise me that I am not obligated to disclose any condition of which I am aware concerning my health or the health of any dependent included on the application, (c) to make any representation concerning health benefits that are inconsistent with, or different from, any written information provided by MMO or (d) to bind MMO in any way by making any statement, promise or representation that is not set out in writing in this application or regarding eligibility, benefits or issuance of a policy, (e) to answer any questions in, or insert any information on, this Application on my behalf, or (f) to approve coverage.
10. I understand and agree that I am responsible for disclosing all information required by this application, including but not limited to all health conditions and diagnoses of which I am aware. I understand and agree that MMO has the exclusive right to determine whether a particular condition or diagnosis is significant, that I do not have the right to evaluate whether a condition or diagnosis should or should not be disclosed on this application and that I am obligated to disclose even those conditions or diagnoses that I do not believe are significant or important.
11. My dependents and I understand and agree that any information obtained will not be released by the Company to any person or organization except to reinsuring companies, the MIB, or other persons or organizations performing health care operations or business or legal services in connection with any application, claim, or as may be otherwise lawfully required, or as we may further authorize. If a Consumer Reporting Agency is used, I (we) may request to be interviewed in connection with the preparation of the report. Once personal and health (including medical, dental, and pharmacy) information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal and state privacy requirements. A copy of this authorization request is available to me or my legal representative upon written request. A photographic copy of this authorization shall be as valid as the original. This authorization shall be valid for a period of two and one-half years. I have the right to revoke this authorization at any time. To revoke this authorization, I must do so in writing and send my written revocation to MMO's Privacy Office. The revocation will not apply to information that has already been released in response to this authorization. The revocation may adversely affect my application, a claim or a pending insurance action. The revocation will become effective after it is received by MMO's Privacy Office.

I am signing this Health Application on my own behalf and on behalf of all listed dependents. An unaltered copy of this authorization is as valid as the original. I understand that I should not cancel any current health insurance coverage until you receive an approval letter and insurance policy from MMO.

Contract Holder's or Guardian's Signature	Date	Guardian's Social Security Number (if child only policy)	
Spouse's Signature	Date	Dependent's Signature if 18 or older	Date
Dependent's Signature if 18 or older	Date	Dependent's Signature if 18 or older	Date

Section VIII: HOW DID YOU HEAR ABOUT SUPERMED ONE? (CHECK ONE)

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> 1. Friend/Family Member | <input type="checkbox"/> 4. Advertisement in newspaper, magazine, etc. | <input type="checkbox"/> 7. Radio | <input type="checkbox"/> 10. Other _____ |
| <input type="checkbox"/> 2. Yellow Pages | <input type="checkbox"/> 5. Newspaper Article | <input type="checkbox"/> 8. Mail | |
| <input type="checkbox"/> 3. Insurance Agent | <input type="checkbox"/> 6. Internet/Web site | <input type="checkbox"/> 9. Through current employer | |

WARNING: Any person who, with intent to defraud or knowing that he is facilitating 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).