



MEDICAL
MUTUAL
OF OHIO®

Employer/Group Enrollment Application & Change Form

Return completed form to:

COSE Health Insurance Program
P.O. Box 94686 • Cleveland, OH 44101-4686

- initial enrollment
- change

Employer Group Enrollment Application/Change Form

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# _____	
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 #	
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. _____					

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"/> 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"/> 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
		Probation Period for Rehire <input type="checkbox"/> Same as above <input type="checkbox"/> Other _____	

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			

*Any employee working at least 25 hours per week is eligible for coverage.

**Including owners, officers and partners who receive compensation from the company, reported on a tax form other than a 1099.

3. Medical Mutual of Ohio® (Medical Mutual) Plans

IS THE EMPLOYER CONTRIBUTION AT LEAST 25% OF EACH CONTRACT <input type="checkbox"/> YES <input type="checkbox"/> NO		PROPOSED EFFECTIVE DATE
**SUPERMED PLUS Multiple Option: <input type="checkbox"/> 100 Plan <input type="checkbox"/> 90 Plan <input type="checkbox"/> 80 Plan	SUPERMED CLASSIC GOLD: <input type="checkbox"/> 250/500 <input type="checkbox"/> 750/1500 <input type="checkbox"/> 500/1000 <input type="checkbox"/> 1000/2000	
SUPERMED PLUS: <input type="checkbox"/> 1000/3000 <input type="checkbox"/> 2080-250 <input type="checkbox"/> 250/500 <input type="checkbox"/> 750/1500 <input type="checkbox"/> 2000/4000 Aggregate <input type="checkbox"/> 3000/9000 <input type="checkbox"/> 500/1000 <input type="checkbox"/> 1000/2000 <input type="checkbox"/> 2000/6000 <input type="checkbox"/> 2080-500	<input type="checkbox"/> HMO Health Ohio** <input type="checkbox"/> MEDIFIL <input type="checkbox"/> MEDIFIL without Drug <input type="checkbox"/> MEDICARE Carve-Out	
SUPERMED PLUS HSA <input type="checkbox"/> 2500/100 <input type="checkbox"/> 3000/100 <input type="checkbox"/> 4000/100 <input type="checkbox"/> 5000/100	<input type="checkbox"/> PRESCRIPTION DRUG CARD* <small>*not available with 1000/2000, 2000/4000, Medifil or HSA plans</small>	
<small>**Prescription Drug Card Included</small>		

4. SuperDental Plans

<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	PROPOSED EFFECTIVE DATE
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5. Vision Service Plans

<input type="checkbox"/> Option 1 (100% employer contribution required) <input type="checkbox"/> Option 2 (25% - 75% employer contribution)	PROPOSED EFFECTIVE DATE
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6.

Fort Dearborn Life Insurance Company Plans

Evidence of Insurability Requirements	# Of Employees Enrolling	Employer Contribution	Proposed Effective Date
*Certain selected amounts may be subject to evidence of insurability approval by Fort Dearborn Life Insurance Company® (FDL).			
<input type="checkbox"/> Basic Life and AD&D (minimum contribution is 25%)		_____%	
<input type="checkbox"/> Dependent Life		_____%	
<input type="checkbox"/> Optional Life (Complete Evidence of Insurability Form)		_____%/	
<input type="checkbox"/> All Employees \$ _____ each (minimum \$10,000, use increments of \$5,000)			
<input type="checkbox"/> All Employees _____ x Base Annual Earnings* rounded to next higher of \$1,000, to a maximum of \$ _____.			
<input type="checkbox"/> Employees according to following class designation: Class Job Titles/Salary Levels (as indicated on the employee application)			Benefit Amount
1. _____			_____
*excluding bonuses, overtime, and other forms of extra pay 2. _____			_____
3. _____			_____
<input type="checkbox"/> Group Short Term Disability* - Maximum weekly benefit \$ _____ (not to exceed \$500)		_____ % Employer Contribution	
<input type="checkbox"/> Optional Short Term Disability* (available only to groups of 2 or more employees)		_____ % of Employees Enrolling	
Select One Plan: <input type="checkbox"/> 1 - 8 - 26 <input type="checkbox"/> 15 - 15 - 26		_____ % of Employees Enrolling	
*Benefits may not exceed 70% of Employee's Basic Weekly Income			
<input type="checkbox"/> Long Term Disability*		_____ % Employer Contribution	
*Employees must work a minimum of 30 hours per week			
Select One Plan: <input type="checkbox"/> 90 day elimination <input type="checkbox"/> 180 day elimination		_____ % of Employees Enrolling	

7.

Current and Prior Carrier History (list current carrier first)

List all carriers used for all health and life insurance offered to the employees for the past 5 years. If there are no carriers, indicate NONE.

CARRIER NAME	BENEFITS*	DATES		CURRENT RATES**				RENEWAL RATES**			
		From	To	Employee	Employee & Spouse	Employee & Child	Family	Employee	Employee & Spouse	Employee & Child	Family
1.											
2.											
3.											

*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. HRS. WORKED PER WEEK PRIOR TO RETIREMENT

9.

Terms And Conditions

1. The group named herein, which is duly organized under the laws of the State of Ohio, hereby applies to the carrier(s) for the benefits selected herein. The group understands and acknowledges if this application is accepted by the carrier(s) selected herein, that the actual benefits will be specified in the contract(s) held by the association responsible for offering these benefit options and that said benefits will take effect on the date specified in a letter that will be forwarded directly from the carrier(s) underwriting the coverage to the group. **This Employer/Group Enrollment Application is not a contract for health care benefits. Continue your current coverage until you are notified in writing that the carrier has accepted this application.**
2. For Groups 1-50 Eligibles: Each employee applying for any Medical Mutual of Ohio® (Medical Mutual™) product must complete **all** sections of the EMPLOYEE APPLICATION, CHANGE FORM AND MEDICAL HISTORY QUESTIONNAIRE.
3. To be eligible for coverage an individual must be a full time employee of the group or company applying for coverage. All individuals who apply for insurance coverage from the carrier(s) must be full-time common law employees, drawing a regular paycheck, whose compensation is reported on IRS Form W-2. Independent contractors to the group or company are not eligible for coverage.
4. To be eligible for coverage, the group or company must be in compliance with all applicable laws of the State of Ohio. By applying for coverage, you agree that Medical Mutual, or any other program carrier may from time to time verify your compliance with the Underwriting eligibility, or participation standards of the pertinent program. You agree to provide payroll records if requested by Medical Mutual, or any other carrier to verify your compliance.
5. Any untrue or incomplete information, statements or answers on this application (whether intentional or not) 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 rescision of coverage for the group or any group member, and may subject the group or any group member to legal action by the carrier.
6. Approval and acceptance of this Employer/Group Enrollment Application and Individual Employee Applications are subject to the carrier’s underwriting guidelines.
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 insurance coverage and it does not permit membership in the group or company solely for the purpose of obtaining insurance coverage.
9. For all groups: Each employee not enrolling must complete the Waiver on the cover page of the EMPLOYEE APPLICATION, AND MEDICAL HISTORY QUESTIONNAIRE.
10. The group hereby authorizes the carrier(s) to obtain information from prior carriers to determine existence of pre-existing conditions. Prior carriers are authorized to release such information to the carrier(s) upon receipt of a copy of this application. Medical Mutual collects this data as a service to you. Checking the boxes does not cause automatic enrollment. The Insurance Carrier(s) must approve this application.
11. The group understands and agrees that no agent or broker has the authority to: (1) to bind Medical Mutual 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 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.

10.

Authorized Signature (Please print)

Business Name	Name (print)	Title
Authorized Signature		Date
Broker Signature (if applicable)	Broker Name (print) (if applicable)	
Fed 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)