Ohio
Universal Application

Group size: 2-50 eligible employees

Medical Mutual of Ohio allows groups of one to enroll using this application.

The Ohio Department of Insurance authorizes the use of this form by the following carriers:

Aetna	Medical Mutual of Ohio	UnitedHealthcare
▪ Aetna Health, Inc ▪ Aetna Health Insurance Company ▪ Aetna Life Insurance Company	▪ Medical Mutual of Ohio ▪ Medical Health Insuring Corporation of Ohio ▪ Consumers Life Insurance Company	▪ UnitedHealthcare of Ohio, Inc ▪ UnitedHealthcare Insurance Company of Ohio ▪ United Healthcare Insurance Company

Please note: All carriers are independent entities.

This universal application is intended to simplify your health insurance application process when your employer has requested quotes from multiple carriers. You only need to complete one application when applying for coverage through Aetna, Medical Mutual and/or UnitedHealthcare. To ensure your privacy rights, you must sign in each carrier's authorization section unless you are waiving coverage. If coverage is being waived, only one signature is required (page 2).

Although one application is being used, ultimately, one carrier and its affiliates/subsidiaries selected by the employer will provide the coverage.

This application may not be used for carriers other than those shown above.

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 Universal Application
Group Size: 2-50* Eligible Employees

* Medical Mutual of Ohio allows for groups of 1 to enroll with this application.

Employer Name	Policy/Group #	Section#	Proposed Effective Date

Group specifics	Reason for Application	Carrier represented	Employee type
Full Time Hire Date: Hours worked/ Week: Position: Salary: $ ☐ Weekly ☐ Monthly ☐ Annual	☐ New Group Plan ☐ New Hire ☐ Currently covered under Employer's medical plan (Change)	☐ Aetna ☐ Medical Mutual of Ohio ☐ UnitedHealthcare	☐ Active ☐ Retired -or- ☐ Cobra COBRA/State Continuation Start date: End date: ☐ Hourly ☐ Salaried ☐ Union ☐ Non-Union or ☐ Othe ________________ **E-mail Address**

Last Name	First Name, M.I.	Social Security Number	Home Phone	Work Phone

Home Street Address, Apt. No.	City	State	Zip
Work Street Address	**City**	**State**	**Zip**

Family information: For court-ordered dependent, legal documentation must be attached.

Last Name First Name, MI.	Social Security Number	Relationship	Sex	Birth Date	Height	Weight	Coverage Status	Smoker (Y or N)
Employee		Self					☐ Single ☐ Divorced ☐ Married ☐ Widowed ☐ Legally Separated	
Spouse		☐ Spouse						
Child		☐ Child ☐ Stepchild ☐ Other					☐ Different Last Name ☐ Lives at another address ☐ Full Time Student +19 ☐ Disabled +19	
Child		☐ Child ☐ Stepchild ☐ Other					☐ Different Last Name ☐ Lives at another address ☐ Full Time Student +19 ☐ Disabled +19	
Child		☐ Child ☐ Stepchild ☐ Other					☐ Different Last Name ☐ Lives at another address ☐ Full Time Student +19 ☐ Disabled +19	
Child		☐ Child ☐ Stepchild ☐ Other					☐ Different Last Name ☐ Lives at another address ☐ Full Time Student +19 ☐ Disabled +19	
Child		☐ Child ☐ Stepchild ☐ Other					☐ Different Last Name ☐ Lives at another address ☐ Full Time Student +19 ☐ Disabled +19	

IMPORTANT: If a dependent does not reside with eligible employee, please provide address on a separate sheet. Please see your employer representative for more information about the qualifications for full-time student status.

Employee Name	Group/Policy #	Social Security Number

Product selection	Medical	Dental (if applicable)	Additional Life Amount (if applicable)	STD (if applicable	LTD (if applicable)	Waiver
Employee	☐	☐	☐	☐	☐	☐ Yes
Spouse	☐	☐	☐	☐	☐	☐ Yes
Dependents	☐	☐	☐	☐	☐	☐ Yes

Life and Disability Coverage: Your non-medical group insurance program may not include all the benefit listed above. Ask your employer for the details about the benefits available to you, your cost, if any, and whether you will be required to submit evidence of insurability.

For multiple option plans indicate plan selection below

Plan Option Selected	Medical	Dental

Life Insurance Beneficiary Designation (For Employee Only: Must be completed if you applied for Life or AD&D insurance)
If two or more primary beneficiaries are named, and you do not list benefit percentages, proceeds will be paid in equal share to the named primary beneficiaries who survive you. If no primary beneficiary survives you, proceeds will be paid to the contingent beneficiary(ies). If you list benefit percentages, the total must equal 100%. (Employee is the beneficiary of proceeds from spouse or child coverage.)

	Full Name	Relationship	Benefit %
Primary:			
Contingent:			
Contingent:			

Other coverage information

Does anyone enrolling on this enrollment form have current or prior coverage? ☐ Yes ☐ No

Proof of current or prior coverage must accompany this enrollment form for pre-existing condition credit and if an employee is waiving coverage. Acceptable forms of proof are:
1. Certificate of Creditable Coverage from prior carrier, or
2. Copy of ID card or most recent payroll stub showing medical coverage deduction, or
3. Copy of most recent medical premium bill from prior carrier

Failure to provide Proof of Prior Coverage may subject you or a family member to the full pre-existing conditions limitation with no credit for prior coverage. You may request a Certificate of Creditable Coverage from your prior carrier.

Name of Covered Individual	Carrier Name	Group Number	Effective Date	Termination Date	Work Status
					☐ Active ☐ Retired
					☐ Active ☐ Retired
					☐ Active ☐ Retired
					☐ Active ☐ Retired

Are you or any of your dependents covered by Medicare? ☐ Yes ☐ No Please attach a copy of the Medicare ID card.	Reason: ☐ Over 65 ☐ Disabled ☐ End Stage Renal Disease ☐ Disabled but actively at work	Covered by Part: ☐ A ☐ B ☐ D	Ineligible for or waived: ☐ A ☐ B ☐ D

If yes, Name of Medicare Beneficiary:	Effective Date:	Claim Number:

Waiver of coverage

I decline coverage for: ☐ Myself ☐ Myself and all dependents ☐ Spouse
☐ Dependent Children: 1. 2. 3. 4.

Declining coverage due to ☐ Spouse's Employer's Plan ☐ Individual Plan ☐ Covered by Medicare ☐ Medicaid ☐ COBRA

Existence of other coverage: ☐ VA Eligibility ☐ Tri-Care ☐ OTHER: _____ ☐ I(we) have no other coverage at this time

I understand that by waiving coverage at this time, I will not be allowed to participate unless I experience a qualified life change event, at the next open enrollment period or as a late enrollee, if applicable. I also understand that pre-existing limitations may apply as explained in each carrier's plan documents including any Rights and Responsibilities Brochure which I may have received with this form or which may be available to me upon request.

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 you 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.

Signature: _____ Date: _____

Medical information

Employee Name

Employer Name	**Policy/Group #**	**Section#**	**Proposed Effective Date**

Have you or any person listed in Section "Family Information" on page one of this form – consulted with or been examined or treated by any health care professional during the last 5 years for any illness, injury, or health condition in any of the categories listed below? If yes, please check the box that most appropriately describes the problem and explain in table provided. **Please note that, if you leave out or misrepresent information, we may terminate or not renew your coverage, or we may change your premium retroactive to the date your policy became effective.**

Heart/ Circulatory/Vascular

☐ Yes (Check all that apply)
☐ None Applicable

☐ Anemia Type_____
☐ Aneurysm Type_____
☐ Angioplasty/Stent
DATE _____
☐ Blood Clot
☐ Blood Disorder Type _____
☐ Bypass DATE_____
☐ CAD/Angina
☐ Congestive Heart Failure
☐ Elevated Cholesterol/
Triglycerides
☐ Heart Attack/Disease
☐ Heart Murmur
☐ Heart Valve Disorder
☐ Hemophilia
☐ Hypertension
☐ Irregular Heart Beat
☐ Pacemaker/ICD Implant
☐ Peripheral Vascular
☐ Stroke
☐ Transplant Type _____
☐ Varicose Veins
☐ Other_____

Brain/Nervous System/ Neurological

☐ Yes (Check all that apply)
☐ None Applicable

☐ Alzheimer's Disease
☐ Amyotrophic Lateral
Sclerosis
☐ Cerebral Palsy
☐ Fainting Spells
☐ Head Injury
☐ Migraines
☐ Multiple Sclerosis
☐ Paralysis
☐ Parkinson's Disease
☐ Seizures/Epilepsy
Date of last seizure_____
Grand ☐ Mal ☐ Petit Mal
☐ Tumor/Growth/Cyst
☐ Other_____

Endocrine

☐ Yes (Check all that apply)
☐ None Applicable

☐ Adrenal Gland
☐ Cirrhosis
☐ Diabetes (Diet/Exercise
Only)
☐ Diabetes (Insulin)
☐ Diabetes (Oral Medication)
☐ Diabetes (Complications)
Last 3 blood sugar readings
_____ _____ _____
☐ Growth Hormones
☐ Hepatitis A, B, C
☐ Liver Disorder
☐ Pituitary
☐ Thyroid Disorder
☐ Transplant
☐ Tumor/Growth/Cyst
☐ Other _____

Lung/Respiratory

☐ Yes (Check all that apply)
☐ None Applicable

☐ Allergies
☐ Asthma
☐ Chronic Bronchitis
☐ COPD /Emphysema;
Oxygen ☐ YES ☐ NO
☐ Cystic Fibrosis
☐ Pneumonia
☐ Sarcoidosis
☐ Sleep Apnea
☐ Transplant Type _____
☐ Tumor/Growth/Cyst
☐ Tuberculosis
☐ Other_____

Reproductive

☐ Yes (Check all that apply)
☐ None Applicable

☐ Abnormal Pap
Normal Follow up? Y/N
Date:_____
☐ Breast cyst or tumor
☐ Breast Implants
☐ Current Pregnancy
Due Date:_____
☐ Multiples expected
☐ Complications thus far
☐ Prior history of complications
☐ Endometriosis
☐ Human Papillomavirus
☐ Infertility
☐ Menstrual Disorders
☐ Polycystic Ovarian Syndrome
☐ Pregnancy Complications
☐ Sexually Transmitted
Diseases (excluding HIV/
AIDS)
☐ Other_____

Immune

☐ Yes (Check all that apply)
☐ None Applicable
☐ Immuno Deficiency Lupus
☐ Discoid ☐ SLE
☐ Psoriasis
Arthritis
☐ Rheumatoid ☐
Osteo
☐ Scleroderma
☐ Other_____

Have you been treated for or had a positive test result for the conditions below?
☐ AIDS
☐ HIV+

Cancer

☐ Yes (Check all that apply)
☐ None Applicable

☐ Basal Squamous
☐ Bone
☐ Breast
☐ Brain
☐ Colon
☐ Ovarian
☐ Leukemia
☐ Cervical
☐ Lymphoma
☐ Prostate
☐ Liver
☐ Lung
☐ Testicular
☐ Other
Lymph node involvement?
☐ YES ☐ NO

Ears/Eyes/Nose/Throat/ Skin

☐ Yes (Check all that apply)
☐ None Applicable

☐ Acne
☐ Acoustic Neuroma
☐ Cataracts
☐ Chronic Ear Infections
☐ Chronic Sinusitis
☐ Cleft Lip/Palate
☐ Deviated Septum
☐ Eczema
☐ Glaucoma
☐ Psoriasis
☐ Retinopathy
☐ Tumor/Growth/Cyst
☐ Other_____

Employee Name

Urinary/Kidney/Bladder	Intestinal/Digestive	Psychological	Bones/Muscles/Joint
☐ Yes (Check all that apply) ☐ None Applicable ☐ Adrenal Gland ☐ Bladder Disorder ☐ Chronic Kidney Stones ☐ Kidney Disorders ☐ Polycystic Kidney Disease ☐ Prostate Disorder ☐ Renal Failure ☐ Transplant TYPE_____ ☐ Tumor/Growth/Cyst ☐ Other _____	☐ Yes (Check all that apply) ☐ None Applicable ☐ Pancreatitis ☐ Colon Disorder/Diverticulitis ☐ Crohn's ☐ Gastric Bypass/Stapling ☐ Gall Stones ☐ Reflux ☐ Tumor/Growth/Cyst ☐ Ulcer ☐ Ulcerative Colitis ☐ Other _____	☐ Yes (Check all that apply) ☐ None Applicable ☐ ADHD/ADD ☐ Alcohol/Drug Abuse ☐ Anxiety/Depression ☐ Autism ☐ Bipolar/Manic Depression ☐ Eating Disorder ☐ Alcohol/Drug ☐ Inpatient MH/Hosp ☐ Schizophrenia ☐ Suicide Attempt ☐ Other _____	☐ Yes (Check all that apply) ☐ None Applicable ☐ Back/Neck Disorder ☐ Bulging/Herniated Disc ☐ Congenital Problem ☐ Degenerative Disc Disease ☐ Fibromyalgia/Chronic Fatigue Syndrome ☐ Implants ☐ Joint Injury/Replacement ☐ Knee ☐ Osteoarthritis ☐ Physical Deformity ☐ Prosthetic Device ☐ Spina Bifida ☐ Tumor/Growth/Cyst ☐ Other _____
Medication	**Transplant**		
☐ Yes (Check all that apply) ☐ None Applicable ☐ Current Medications ☐ Medications Taken Within the Past Year: _____	☐ Yes (Check all that apply) ☐ None Applicable ☐ Discussed Possible Future Transplant ☐ Organ _____ ☐ Other _____		

Please give details below (if additional space is required, please attach a separate sheet and be sure to date and sign that sheet)

Family Member/ Dependent	Condition/ Diagnosis	Treatment/ Complications	Physician's Name	Dates Treated	Prognosis

Authorization for the Use and Disclosure of Information

UnitedHealthcare

I authorize United HealthCare Insurance Company and its affiliates ("UnitedHealthcare and Affiliates") to obtain, use and disclose my medical, claim or benefit records, including any individually identifiable health information contained in these records. I understand these records may contain information created by other persons or entities (including health care providers) as well as information regarding the use of drug, alcohol, HIV/AIDS, mental health (other than psychotherapy notes), sexually transmitted disease and reproductive health services. I authorize any health care provider, pharmacy benefit manager, other insurer or reinsurer, hospital, clinic or other medical facility, health care clearinghouse, and any of their affiliates, representatives or business associates, to disclose my information to UnitedHealthcare and Affiliates. I understand the purpose of the disclosure and use of my information is to allow UnitedHealthcare and Affiliates to make decisions regarding eligibility, enrollment, underwriting and premium risk rating. I understand this authorization is voluntary and I may refuse to sign the authorization. My refusal may, however, affect my ability to enroll in the health plan or receive benefits, if permitted by law. I understand I may revoke this authorization at any time by notifying UnitedHealthcare and Affiliates in writing at the address provided, except to the extent that action has already been taken in reliance on this authorization. I further understand the information I authorize a person or entity to obtain and use may be re-disclosed and no longer protected by federal privacy regulations. This authorization, unless revoked earlier, expires 30 months after the date it is signed. 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. I understand that I am completing a joint life and health application and that each response must be complete and accurate. I (we) request the indicated group medical coverage for myself and, if the plan provides, for my dependents. I authorize any required premium contributions to be deducted from earnings. I (we) have not given the agent or any other persons any health information not included on the application. I (we) understand that UnitedHealthcare and Affiliates is not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on this application and any attachments. I have a continuing obligation to report changes in health status (e.g. received medical advice, diagnosis, care or treatment) after I sign the enrollment form and before receipt of my identification card. Please maintain a copy of this authorization for your records.

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.

Name: _____ Date: _____Spouse: _____ Date: _____

Signature: _____ Signature (If applicable & available): _____

If you have not received a copy of your UnitedHealthcare rights and responsibilities brochure with this application, please tell your employer. At your employer's request, UnitedHealthcare will provide a printed brochure to you.

Coverage Provided by "UnitedHealthcare and Affiliates":
Medical/Dental coverage provided by United HealthCare Insurance Company or United HealthCare Insurance Company of Ohio or United HealthCare of Ohio, Inc. Life Insurance coverage provide by United HealthCare Insurance Company or United HealthCare Insurance Company of Ohio. Vision coverage provided by United HealthCare Insurance Company or United HealthCare Insurance Company of Ohio.

Aetna

Conditions of Enrollment

On behalf of myself and the dependents listed, I agree to or with the following:

1. I acknowledge that by enrolling in the following plans, coverage is provided by the following entities (collectively referred to as "Aetna"):
   - Aetna Choice® POS (Open Access) and Aetna Open Access HMO: Aetna Health Insurance Company and/or Aetna Health Inc.
   - Aetna Open Choice® PPO: Aetna Life Insurance Company
   - Life, Accidental Death & Dismemberment, disability, dental and all other coverages: Aetna Life Insurance Company
2. I understand and agree that my employer's application will determine coverage and that there is no coverage unless and until both this enrollment form and the employer application have been accepted by Aetna. Even if this enrollment form is accepted, any intentional and material misstatements or omissions that amount to fraud may result in future claims being denied and my coverage under the policy being rescinded or reevaluated, as of the effective date, for eligibility and rating purposes except as otherwise provided by law.
   For life and disability coverages: I understand that the effective date of insurance for myself or for any of my dependants is subject to my being actively at work on that date and that the effective date of insurance for any of my dependents is also subject to the dependent health condition requirements of the benefit plan. Further, I understand that any insurance subject to evidence of good health or medical information will not become effective until Aetna gives its written consent.

3. I understand and agree that this Enrollment form may be transmitted to Aetna or its agent by my employer or its agent. I authorize any physician, other healthcare professional, hospital or any other healthcare organization ("Providers") including pharmacies or pharmacy database benefit managers to give to Aetna or its agent information concerning the medical history, services or treatment provided to anyone listed on this Enrollment form, including those involving mental health, substance abuse and HIV/AIDS. I further authorize Aetna to use such information and to disclose such information to affiliates, providers, payors, other insurers, third party administrators, vendors, consultants and governmental authorities with jurisdiction when necessary for my care or treatment, payment for services, the operation of my health plan, or to conduct related activities. I have discussed the terms of this authorization with my spouse and competent adult dependents, and I have obtained their consent to those terms. Authorizations signed for the purpose of collecting information in connection with this application for an insurance policy, a policy reinstatement or a request for a change in policy benefits shall remain valid for thirty months from the date it is signed. Authorizations signed for the purpose of collecting information in connection with a claim for benefits shall remain valid for the term of this coverage or for so long as allowed by law. I understand that I am entitled to receive a copy of this authorization upon request and that a photocopy is as valid as the original.
4. The plan documents will determine the rights and responsibilities of member(s) and will govern in the event they conflict with any benefits comparison, summary or other description of the plan.
5. I understand and agree that providers and vendors are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change.
6. I understand and agree that, with certain exceptions described in the plan documents, HMO and DMO plans only provide coverage for referred benefits, and that, in order to be covered, services must be performed either by a participating primary care physician, primary care dentist, or by the participating specialist, hospital, pharmacy, dentist, or other provider as authorized by a referral from a participating primary care physician.
7. I understand and agree that, as described in the plan documents, when enrolled for medical coverage other than HMO plan, any pre-existing conditions for my spouse, dependents or myself may not be covered for 12 months.

Misrepresentation

8. Any person who knowingly and with intent to defraud any insurance company or other person files an enrollment form 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.

Name: _____ Date: _____ Spouse: _____ Date: _____

Signature: _____ Signature (If applicable & available): _____

Medical Mutual of Ohio

Pre-existing condition notice

The following information is attached to and incorporated into your application to Medical Mutual:
This plan imposes a pre-existing condition exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within no more than a six-month "look-back" period. Generally, this look-back period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the look-back period ends on the day before the waiting period begins. The pre-existing condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 30 days after birth, adoption, or placement for adoption. This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the maximum 12-month (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage. All questions about the pre-existing condition exclusion and creditable coverage should be directed to CustomerService@MedMutual.com or your sales representative.

Terms and conditions

I hereby apply to Medical Mutual for the coverage indicated on this application

- I acknowledge that by enrolling in the following products, coverage is provided by the following entities (collectively referred to as "Medical Mutual"):
  - Super Med PPO or POS plans: Medical Mutual of Ohio
  - Super Med HMO or HMO Health Ohio: Medical Health Insuring Corporation of Ohio
  - Life, Accidental Death & Dismemberment, disability: Consumers Life Insurance Company
- I authorize: (1) payroll deduction(s) and remittance of any required contribution for coverage to Medical Mutual, including any affiliates or divisions of Medical Mutual; (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 the denial of a claim or rescission of coverage and may subject me to legal action by Medical Mutual; (2) to be eligible for health coverage, I must be an active full-time employee, as defined by policy; (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 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.
- I understand that if my personal health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
- I understand that I have a right to revoke this authorization at any time. My revocation must be in writing. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my personal health information have acted in reliance upon this authorization.
- I understand and acknowledge that this authorization extends to all medical records, including records which may contain information regarding treatment for physical and mental illness, alcohol/drug use and/or HIV-AIDS test results or diagnosis. I expressly consent to the release of such information.
- I understand that the applicable certificate or evidence of coverage will determine the rights and responsibilities of covered persons and will govern in the event they conflict with any benefits comparison, summary or other description of the plan.
- I understand that if I choose HMO coverage, the HMO restricts enrollee access to health care providers. Benefits are payable only for covered services that are provided by a Network Physician unless otherwise approved by MIHCO. This applies to all covered services except Emergency Services. The HMO will furnish you with a list of plan physicians and plan facilities upon enrollment and/or request. 2. Right of Cancellation: If you are obligated to share in the cost of this coverage, you may cancel this application within 72 hours after you have signed this application. Cancellation will occur when written notice is given to MIHCO. Notice of cancellation shall be considered given when you mail a letter to MIHCO.

- ***For life and disability coverage:*** I understand that being **Actively at Work** is a requirement for coverage. If I am **not Actively at Work** on the day this coverage would otherwise be effective, the effective date of this coverage will be the date of my return to **Active Work**. If I do not return to **Active Work**, I will not be covered. 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 the policy or plan document; and satisfies any other conditions required by the applicable group life or disability policy.

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. I understand that I should not cancel any current insurance coverage until I receive an approval letter and insurance certificate from Medical Mutual.

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.

Name: _____ Date: _____ Spouse: _____ Date: _____

Signature: _____ Signature (If applicable & available): _____