



Application Instructions

1. Download and print all pages of the application, including instructions.
2. Complete all questions and sections of the application. Be sure to:
 - Write clearly using a blue or black ballpoint pen.
 - Choose a plan and optional benefits.
 - Indicate your requested effective date.
 - Select your preferred billing method.
 - Sign and date the application.
3. Complete the fax cover letter on the next page and fax both the cover letter and the application to 330/721-8815.

If you do not have access to a fax machine, send the completed application and any additional documents to:

Medical Mutual of Ohio
Attn: SuperMed One new enrollment
P.O. Box 239
Litchfield, OH 44253

If you wish to verify receipt of your application after submission, please call 800/722-7331.

Next Steps

Medical Mutual will review your application for completeness and accuracy before submitting to the underwriting department for processing. You will be notified of your acceptance and estimated monthly premium amount within five to seven business days. (Note: Medical Mutual will not review this application until the following business day if faxed after 5 p.m. or on a weekend.)

If you accept the terms of the policy and the premium amount, your application will be fully processed. Please be sure to carefully review your policy, including the effective date, premium amount, benefits limitations, exclusions and riders.

The rates quoted are estimates only and are subject to change based on your medical history, the underwriting practices of Medical Mutual, the optional benefits selected, if any, and other relevant factors. Medical Mutual reserves the right to change the terms of the policy under proper notification.

Payment Instructions

If you have requested that your monthly premium be deducted automatically from a checking or savings account, you must attach a voided check or deposit slip with your application. Be sure to complete, sign and date the authorization form.

If an effective date other than the first of the month is selected, your first invoice, deduction or credit card charge will reflect more than one month's premium.

Important Note

Do not cancel any current health insurance coverage until you receive a notification of approval from Medical Mutual. Soon after you will receive your identification card and plan certificate.

If you have any questions about the application process, please call 800/722-7331 or e-mail sm1@insureonebenefits.com.





MEDICAL MUTUAL OF OHIO®
YOUR HEALTHCARE PARTNER SINCE 1934

FAX COVER LETTER

(This form needs to be completed if you will be faxing your application.)

TO: Medical Mutual

Attn: SuperMed One new enrollment

Fax: 330/721-8815

FROM: Name: _____

E-mail: _____

Phone: _____

Date: _____

Time: _____

Please accept my completed insurance application for review.

If you wish to verify receipt of your application after submission, please call 800/722-7331.

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

HEALTH AND LIFE APPLICATION/CHANGE FORM – OHIO

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

Section I: Applicant Information

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

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

Section II: Federal and Ohio Open Enrollment Eligibility

1. Are you a **Federally Eligible Individual** or applying for coverage under the **Ohio Open Enrollment** requirements? Yes No
 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 800/235-7655. SuperMed One may affect your status as a federally eligible individual. Visit the ohioinsurance.gov Web site for more information.

Requested effective date: ____ / ____ / ____ (when coverage is to begin)

Section III: Products

<p>Elite Plans w/Office Copay</p> <p><input type="checkbox"/> \$500/\$1000 <input type="checkbox"/> \$1000/\$2000 <input type="checkbox"/> \$1500/\$3000 <input type="checkbox"/> \$2500/\$5000</p> <p>Elite Plans w/o Office Copay</p> <p><input type="checkbox"/> \$2500/\$5000 <input type="checkbox"/> \$5000/\$10000 <input type="checkbox"/> \$10000/\$20000</p> <p>Optional Riders</p> <p><input type="checkbox"/> Prescription Drug (\$15/\$30/\$60) <input type="checkbox"/> Maternity Services <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life (complete sections III & IV)</p>	<p>Premium Plans w/Office Copay</p> <p><input type="checkbox"/> \$500/\$1000 <input type="checkbox"/> \$1000/\$2000 <input type="checkbox"/> \$1500/\$3000 <input type="checkbox"/> \$2500/\$5000</p> <p>Optional Riders</p> <p><input type="checkbox"/> Prescription Drug (\$15/\$30/\$60) <input type="checkbox"/> Maternity Services <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life (complete sections III & IV)</p>	<p>Wellness HSA</p> <p><input type="checkbox"/> \$1500/\$3000 <input type="checkbox"/> \$2500/\$5000 <input type="checkbox"/> \$3000/\$6000 <input type="checkbox"/> \$5000/\$10000</p> <p>Value Plans</p> <p><input type="checkbox"/> \$500/\$1000 <input type="checkbox"/> \$1000/\$2000 <input type="checkbox"/> \$1500/\$3000</p> <p>Optional Riders</p> <p><input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life (complete sections III & IV)</p>	<p>Ancillary Coverage¹</p> <p><input type="checkbox"/> Dental <input type="checkbox"/> Vision</p>
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¹ Dental 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 III: Products (continued)

Applicant Basic Life Insurance

 \$10,000 \$20,000 \$30,000 \$40,000 \$50,000

Spouse Basic Life Insurance

 \$10,000 \$20,000 \$30,000 \$40,000 \$50,000

Dependent Life Insurance

 \$10,000Do you, the applicant, own an existing life policy or annuity contract? Yes No (answer by checking one)**If you answered "YES" to the above questions, inform the agent** who will provide you an "Important Notice: Appendix A, which you must read and complete.

By applying for this proposed life policy, do you intend to replace, discontinue or change any existing life policy or annuity contract?

 Yes No (answer by checking one)

It is understood and agreed that this application shall be made part of the Policies for which application is made, and it is further understood:

- (1) Basic Life and Dependent Life are subject to the approval of Consumers Life Insurance Company (CLIC), and nothing contained herein shall be binding upon Consumers Life until this application is approved and accepted at CLIC's home office.
- (2) No waiver or change will bind CLIC unless signed by an Executive Officer of CLIC.

Section IV: Applicant Beneficiary Designation

If two or more primary beneficiaries are named, and you do not list benefit percentages, proceeds will be paid in equal shares 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%.

LAST NAME	FIRST NAME	DATE OF BIRTH	RELATIONSHIP	BENEFIT %
Primary		/ /		%
Primary		/ /		%
Contingent		/ /		%
Contingent		/ /		%

Spouse Beneficiary Designation

If two or more primary beneficiaries are named, and you do not list benefit percentages, proceeds will be paid in equal shares 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%. (If no beneficiary is designated, then the Applicant is the beneficiary of proceeds from spouse or child coverage.)

LAST NAME	FIRST NAME	DATE OF BIRTH	RELATIONSHIP	BENEFIT %
Primary		/ /		%
Primary		/ /		%
Contingent		/ /		%
Contingent		/ /		%

Section V: OTHER COVERAGE INFORMATION

1. 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: Yes No

NAME	TYPE	NAME OF INSURANCE COMPANY

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

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

Section VI: MEDICAL ELIGIBILITY

IMPORTANT: Your Medical history will determine eligibility. Please answer all medical eligibility questions completely. Use additional paper, if necessary. Incomplete applications will be returned.

A. 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**)? Yes No

Name	Due Date
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B. Does **ANY PERSON TO BE COVERED** have a condition covered by Workers' Compensation? Yes No

NAME	WORKERS' COMPENSATION NUMBER	MEDICAL CONDITION

Section VI: MEDICAL ELIGIBILITY (continued)

C. 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 (excluding HIV and AIDS) 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"/>	32. Diverticulitis/Diverticulosis	<input type="checkbox"/>	<input type="checkbox"/>	63. Mental Health Disorders	<input type="checkbox"/>	<input type="checkbox"/>
2. Allergies	<input type="checkbox"/>	<input type="checkbox"/>	33. Down's Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	(Including Depression,		
3. Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>	34. Drug/Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety, ADD/ADHD and		
4. Anemia (Type: _____)	<input type="checkbox"/>	<input type="checkbox"/>	(Including Arrests/			counseling)		
5. Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	Convictions)			64. Migraines	<input type="checkbox"/>	<input type="checkbox"/>
6. Anorexia/Bulimia	<input type="checkbox"/>	<input type="checkbox"/>	35. Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>	65. Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
7. Arthritis (Type: _____)	<input type="checkbox"/>	<input type="checkbox"/>	36. Fibrocystic Breast Disease	<input type="checkbox"/>	<input type="checkbox"/>	66. Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>
8. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	37. Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	67. Organ Transplant/Failure	<input type="checkbox"/>	<input type="checkbox"/>
9. Back Sprains/Strains	<input type="checkbox"/>	<input type="checkbox"/>	38. Gallbladder Disease	<input type="checkbox"/>	<input type="checkbox"/>	68. Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
10. Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	39. Gastric Reflux (GERD)	<input type="checkbox"/>	<input type="checkbox"/>	69. Otitis Media (ear infections)	<input type="checkbox"/>	<input type="checkbox"/>
11. Bursitis	<input type="checkbox"/>	<input type="checkbox"/>	40. Gastric Bypass / Banding	<input type="checkbox"/>	<input type="checkbox"/>	70. Ovarian Cyst/Polycystic	<input type="checkbox"/>	<input type="checkbox"/>
12. Cancer (Type: _____)	<input type="checkbox"/>	<input type="checkbox"/>	41. Gout	<input type="checkbox"/>	<input type="checkbox"/>	Ovarian Disease		
13. Cardiomyopathy	<input type="checkbox"/>	<input type="checkbox"/>	42. Graves Disease	<input type="checkbox"/>	<input type="checkbox"/>	71. Pacemaker Implantation	<input type="checkbox"/>	<input type="checkbox"/>
14. Carotid Artery Disease	<input type="checkbox"/>	<input type="checkbox"/>	43. Growth Deficiency	<input type="checkbox"/>	<input type="checkbox"/>	72. Pancreatitis	<input type="checkbox"/>	<input type="checkbox"/>
15. Carpel Tunnel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	44. Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	73. Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
16. Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	45. Heart Bypass Grafting	<input type="checkbox"/>	<input type="checkbox"/>	74. Parkinson's Disease	<input type="checkbox"/>	<input type="checkbox"/>
17. Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	46. Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	75. Peptic/Gastric Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
18. Cholesterol (High)	<input type="checkbox"/>	<input type="checkbox"/>	47. Heart Palpitations/	<input type="checkbox"/>	<input type="checkbox"/>	76. Peripheral Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>
19. COPD or Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Arrhythmia	<input type="checkbox"/>	<input type="checkbox"/>	77. Phlebitis/Blood Clot	<input type="checkbox"/>	<input type="checkbox"/>
20. Cirrhosis of the Liver	<input type="checkbox"/>	<input type="checkbox"/>	48. Heart Valve Disorders	<input type="checkbox"/>	<input type="checkbox"/>	78. Polycystic Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
21. Colitis (Including Ulcerative)	<input type="checkbox"/>	<input type="checkbox"/>	49. Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	79. Prostate Disorders	<input type="checkbox"/>	<input type="checkbox"/>
22. Colon Polyps	<input type="checkbox"/>	<input type="checkbox"/>	50. Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	80. Schizophrenia/Bipolar	<input type="checkbox"/>	<input type="checkbox"/>
23. Congenital Disorders	<input type="checkbox"/>	<input type="checkbox"/>	51. Hydrocephalus/Shunt	<input type="checkbox"/>	<input type="checkbox"/>	81. Scleroderma	<input type="checkbox"/>	<input type="checkbox"/>
24. Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	52. Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	82. Seizure Disorder/Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
25. Coronary Artery Disease	<input type="checkbox"/>	<input type="checkbox"/>	(High Blood Pressure)			83. Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>
(Including Angina and			Last 3 Pressures & Dates:			84. Skin Conditions (includes	<input type="checkbox"/>	<input type="checkbox"/>
Angioplasty)			1) _____			Acne, Psoriasis, Rosacea,		
26. Coronary Insufficiency	<input type="checkbox"/>	<input type="checkbox"/>	2) _____			Nail Fungus, Eczema)		
27. Crohns Disease	<input type="checkbox"/>	<input type="checkbox"/>	3) _____			85. Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>
28. Cystic Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	53. Ileostomy/Colostomy	<input type="checkbox"/>	<input type="checkbox"/>	86. Spina Bifida Cystica/Occulta	<input type="checkbox"/>	<input type="checkbox"/>
29. Cystitis (Chronic or	<input type="checkbox"/>	<input type="checkbox"/>	54. Infertility	<input type="checkbox"/>	<input type="checkbox"/>	87. Spinal Disorders/	<input type="checkbox"/>	<input type="checkbox"/>
interstitial)	<input type="checkbox"/>	<input type="checkbox"/>	55. Irritable Bowel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	Disc Disease		
30. Cysts, Tumors or Growths	<input type="checkbox"/>	<input type="checkbox"/>	56. Joint Replacement	<input type="checkbox"/>	<input type="checkbox"/>	88. Stroke	<input type="checkbox"/>	<input type="checkbox"/>
31. Diabetes/	<input type="checkbox"/>	<input type="checkbox"/>	57. Kidney Failure	<input type="checkbox"/>	<input type="checkbox"/>	89. Suicide Attempts/	<input type="checkbox"/>	<input type="checkbox"/>
Blood Sugar Disorder			58. Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	Psych Admits		
Last 3 Blood Sugars & Dates:			59. Liver Disorders/Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	90. Systemic Lupus	<input type="checkbox"/>	<input type="checkbox"/>
1) _____			60. Lou Gehrig's Disease (ALS)	<input type="checkbox"/>	<input type="checkbox"/>	91. Tendonitis	<input type="checkbox"/>	<input type="checkbox"/>
2) _____			61. Meningitis	<input type="checkbox"/>	<input type="checkbox"/>	92. Thyroid Disorder	<input type="checkbox"/>	<input type="checkbox"/>
3) _____			62. Menstrual Disorders	<input type="checkbox"/>	<input type="checkbox"/>	93. TMJ	<input type="checkbox"/>	<input type="checkbox"/>
			(including Abnormal			94. Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>
			Cycles/Uterine Bleeding)			95. Transient Ischemic	<input type="checkbox"/>	<input type="checkbox"/>
						Attacks (TIA)		
						96. Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>

D. In the past ten years, has **ANY PERSON TO BE COVERED** been treated, advised to seek treatment or considered treatment, been diagnosed, undergone surgery, been confined to a hospital, consulted a physician, or taken prescription medication for any illness, injury, medical abnormality or mental or emotional condition not stated in questions A-C?
 Yes No

E. Has **ANY PERSON TO BE COVERED** ever been diagnosed as having AIDS, or an AIDS-related condition or had a positive test result on an HIV test?
 Yes No

Section VII: BILLING INFORMATION

CHOOSE ONE:

HOME – Receive monthly premium billings

FINANCIAL INSTITUTION – Monthly automatic premium payments

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

I authorize Medical Mutual of Ohio®/Consumers Life Insurance Company® to initiate premium payments from my account. The authorization will remain in effect until Medical Mutual of Ohio/Consumers Life Insurance Company and my financial institution have received written notification from me within a reasonable time period to allow termination of the payment arrangement.

Premiums are to be deducted on 1st business day of the month. (Please note: Not all Financial Institutions allow deductions from a savings account. Please verify this information with your financial institution.)

In case of insufficient funds, a \$20 returned check fee will be applied.

Name and branch of bank/financial institution			Account Number
Address			Account Holder's Name
City	State	Zip Code	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 (charged on 1st business day of the month)

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

Mastercard Visa Discover American Express

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

LIST BILLING THROUGH EMPLOYER – is available only to **two or more** 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	Area Code and 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 Code

ATTACH VOIDED CHECK OR DEPOSIT SLIP HERE

Section VIII: TERMS AND CONDITIONS

I hereby apply under Medical Mutual of Ohio's (MMO's) Group Trust/Group Association Plan for the health insurance coverage indicated on this application and to Consumers Life Insurance Company (CLIC) for the individual policy of life insurance coverage indicated on this application. If applying under the trust, 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), prescription history database supplier, government agency or person to MMO/CLIC and/or any affiliates or division of MMO/CLIC: (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/CLIC 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 and Life 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 and Life 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/CLIC, 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/CLIC 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, if applicable, upon making such a written request to MMO/CLIC.
5. No issuance, waiver, modification or change of policy or any of MMO/CLIC rules or amendments shall be binding upon MMO/CLIC unless it is in writing and signed by an authorized officer of MMO/CLIC, 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. I agree to advise Medical Mutual about any changes in health status that occur between the date I sign this application and the date the coverage becomes effective. I understand that this information may cause the rates to be adjusted or the offer of coverage to be rescinded.
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/CLIC 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/CLIC or (d) to bind MMO/CLIC 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/CLIC 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.

Section VIII: TERMS AND CONDITIONS (continued)

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/CLIC'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/CLIC's Privacy Office.
12. I understand that I have the right to cancel this coverage within 10 days of receipt of my Certificate of Coverage with a full refund of any premium paid.

Applicant'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 IX: 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"/> 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 |
| <input type="checkbox"/> 10. Other _____ | | |
| _____ | | |

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).

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