



## 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](mailto: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.

|                                    |
|------------------------------------|
| <b>MMO USE ONLY</b>                |
| EFFECTIVE DATE: ____ / ____ / ____ |
| GROUP NUMBER: _____                |

## SHORT TERM 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         |  | Social Security 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 | Best Contact # ( ) |  | Alternate # ( )        |                   |
| 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<br>(and last name, if different) | Social Security<br>Number | Birth Date | Sex | Height | Weight | Tobacco User  |
|--------|---|---------------------------|------------|-----|--------|--------|---|
| Self   |   |                           |            |     |        |        | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Spouse |   |                           |            |     |        |        | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 1      |   |                           |            |     |        |        | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 2      |   |                           |            |     |        |        | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 3      |   |                           |            |     |        |        | <input type="checkbox"/> Y <input type="checkbox"/> 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 800/235-7655. SuperMed One may affect your status as a federally eligible individual. Visit the ohioinsurance.gov web site for more information.

### Section III: Coverage Options

Requested Effective date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**SuperMed One Short Term:**  
*Deductible Single/Family*

- \$250/\$500       \$500/\$1,000  
 \$1,000/\$2,000       \$1,500/\$3,000

### Section IV: OTHER COVERAGE INFORMATION

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 |
|------|------|---------------------------|
|      |      |                           |
|      |      |                           |
|      |      |                           |
|      |      |                           |
|      |      |                           |

**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).

**Section V: MEDICAL ELIGIBILITY QUESTIONS**

1. 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**
2. Is ANY PERSON TO BE COVERED currently hospitalized or in a nursing home? **YES**  **NO**
3. Has any insurance company refused coverage to ANY PERSON TO BE COVERED? **YES**  **NO**   
If yes, please explain \_\_\_\_\_
4. Within the last 12 months have YOU or ANY PERSON TO BE COVERED taken any prescription medications? **YES**  **NO**   
If yes, please list all medications\* \_\_\_\_\_
5. Within the last five years, have YOU or ANY PERSON TO BE COVERED received any medical or surgical consultation, advice, or treatment for any chronic illness including: heart or circulatory system disorders; neurological disorders; respiratory disorders; immune system disorders, including Acquired Immune Deficiency Syndrome (AIDS); cancer or tumor; diabetes; alcoholism or alcohol abuse; drug abuse or chemical dependency? **YES**  **NO**   
If yes, please provide details (include dates of treatment)\* \_\_\_\_\_

\_\_\_\_\_  
\*If more space is required please attach additional sheets.

**Section VI: 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 _____             |

**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 to Medical Mutual of Ohio's (MMO's) Group Trust/Group Association Plan for the 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 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 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 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 the policy for which I am applying 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 the 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.
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. 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 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; (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 condition 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 re-disclosed 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.
12. 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 abuse and/or HIV – AIDS test results or diagnosis. I expressly consent to the release of such information.
13. 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.

I am signing this 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 I 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

**FOR OFFICE USE ONLY**

|                                      |           |                         |                      |
|--------------------------------------|-----------|-------------------------|----------------------|
| Sold – Account Executive and Code    | <b>or</b> | Agent of Record         | Tax I.D.             |
| Service – Account Executive and Code |           | Royal Advantage® Broker | Commission Indicator |