



| 4. SuperDental Plans               |   |                                       |   |  |  | Proposed Effective Date |
|------------------------------------|---|---------------------------------------|---|--|--|-------------------------|
| <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 |  |                         |

| 5. Vision Plans   |   | Proposed Effective Date |
|---|---|-------------------------|
| VSP (Vision Service Plan)   |   |                         |
| <input type="checkbox"/> Option 1 (100% employer contribution required) | <input type="checkbox"/> Option 2 (25% – 75% employer contribution) |                         |

| 6. Life and Disability Plans |                      |                               |                                       |  | Proposed Effective Date                       |
|------------------------------|----------------------|-------------------------------|---------------------------------------|--|---|
| Contributions:               | Life/AD&D            | <input type="checkbox"/> 100% | <input type="checkbox"/> Other _____% | Waiting Period (if different from medical)                                     | # of Employees Eligible _____                 |
|                              | Voluntary Life       | <input type="checkbox"/> 100% | <input type="checkbox"/> Other _____% | <input type="checkbox"/> None  | # of Employees Enrolling _____                |
|                              | STD                  | <input type="checkbox"/> 100% | <input type="checkbox"/> Other _____% | <input type="checkbox"/> First of the month following completion of _____ days | <input type="checkbox"/> Rates are guaranteed |
|                              | Voluntary STD        | <input type="checkbox"/> 100% | <input type="checkbox"/> Other _____% | <input type="checkbox"/> Other _____   | for _____ months                              |
|                              | Dependent Life       | <input type="checkbox"/> 100% | <input type="checkbox"/> Other _____% | Waiting period applies to:   |   |
|                              | Long Term Disability | <input type="checkbox"/> 100% | <input type="checkbox"/> Other _____% | <input type="checkbox"/> All Employees   | <input type="checkbox"/> New Employees only   |
|                              | Other _____          | <input type="checkbox"/> 100% | <input type="checkbox"/> Other _____% |  |   |

**Schedule of Benefits**

**A. Class Definitions** (if more than one class, definitions must be specific)

Class 1 \_\_\_\_\_

Class 2 \_\_\_\_\_

Class 3 \_\_\_\_\_

Class 4 \_\_\_\_\_

**Employees working less than \_\_\_\_\_ hours per week are not eligible for coverage unless otherwise noted above.**

**B. Selection of Coverage(s)** (check all that apply and fill in all applicable blanks)

| Class | <input type="checkbox"/> Basic Life Insurance<br>Amount of Insurance | <input type="checkbox"/> Basic AD&D<br>Principal Sum | <input type="checkbox"/> Supplemental Life<br>Amount of Insurance | <input type="checkbox"/> Supplemental AD&D<br>Principal Sum | <input type="checkbox"/> Short-Term Disability<br>Weekly Maximum |
|-------|--|--|---|---|--|
| 1     | _____  | _____  | _____   | _____   | _____  |
| 2     | _____  | _____  | _____   | _____   | _____  |
| 3     | _____  | _____  | _____   | _____   | _____  |
| 4     | _____  | _____  | _____   | _____   | _____  |

1. Weekly STD benefit is subject to a maximum of \_\_\_\_\_% of employee's Basic Weekly Wage.
2. STD Benefits Payable: \_\_\_\_\_ day of Accident; \_\_\_\_\_ day of Sickness for a maximum benefit period of \_\_\_\_\_ weeks.
3. 1st day Hospital?  Yes  No
4. STD Benefits payable for non-occupational disabilities only.
5. All benefits terminate at retirement unless otherwise noted in class definition section.
6. STD Benefits not available for employees working in CA, HI, NJ, NY, PR or RI.
7. Life or AD&D benefits include 24 hour coverage.
8. If Life or AD&D benefits are based upon a multiple of salary, benefit amounts should be rounded to:
  - the next higher multiple of \$1,000
  - the nearest multiple of \$1,000
  - other \_\_\_\_\_
9. Basic Life and AD&D benefits reduce by:
  - 50% at age 70; and further reduces to 25% of the face amount at age 75
  - 35% at age 65; and further reduces 35% every 5 years thereafter
  - \_\_\_\_\_% at age 65; and further reduces \_\_\_\_\_% of the face amount at age \_\_\_\_\_; and further reduces to \_\_\_\_\_% of the face amount at age \_\_\_\_\_.
10. Supplemental Life and AD&D benefits reduce by:
  - 35% at age 65; and further reduces to 50% of the face amount at age 70
  - 35% at age 65; and further reduces 35% every 5 years thereafter
  - \_\_\_\_\_% at age 65; and further reduces \_\_\_\_\_% of the face amount at age \_\_\_\_\_; and further reduces to \_\_\_\_\_% of the face amount at age \_\_\_\_\_.
11. Voluntary Life benefits terminate at retirement.

**6. Life and Disability Plans (continued)**

**Group Long-Term Disability**

\*Employees must work a minimum of 30 hours per week

**Select One Plan:**

90 day elimination       180 day elimination       Other \_\_\_\_\_

**Dependent Life Insurance**

Spouse: \$ \_\_\_\_\_

Child(ren): \$ \_\_\_\_\_ Live birth but less than 14 days

\$ \_\_\_\_\_ Age 14 days but less than 6 months

\$ \_\_\_\_\_ Age 6 months but less than 21 years

\$ \_\_\_\_\_ Age 21 years but less than \_\_\_\_\_ (if full time student(s) and dependent upon the insured for support)

**Voluntary Life Insurance**

Increments of \$10,000 to a maximum of \$300,000

**Voluntary Short-Term Life Disability**

Increments of \$50; minimum of \$100 to a maximum of \$500, not to exceed 70% of employee's Basic Weekly Wage.

**Select One:**

Voluntary STD benefits payable: 1st day of Accident; 8th day of Sickness for a maximum benefit period of 26 weeks.

Voluntary STD benefits payable: 15th day of Accident; 15th day of Sickness for a maximum benefit period of 26 weeks.

**C. Non-Medical Maximum** (amounts in excess of the amount stated are subject to satisfactory evidence of insurability)

**Life:** Basic \$ \_\_\_\_\_ Supplemental: \$ \_\_\_\_\_ Combined Basic and Supplemental: \$ \_\_\_\_\_

**STD:** \$ \_\_\_\_\_ Other: \$ \_\_\_\_\_ \$ \_\_\_\_\_

**D. Active Work**

As of the proposed effective date, are any of your employees **not Actively at Work** (as defined above) **and, therefore, not eligible for coverage?**

Yes  No If yes, please provide the following information: (Attach a signed dated sheet if more space is needed)

A. Name \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date Last Worked \_\_\_\_\_

Reason not Actively at Work:  Disability  Family Leave  Other \_\_\_\_\_

B. Name \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date Last Worked \_\_\_\_\_

Reason not Actively at Work:  Disability  Family Leave  Other \_\_\_\_\_

### 7. Current and Prior Carrier History

List all carriers used for all product lines of 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        | & Spouse | & Child | Family | Employee        | & Spouse | & Child | Family |
|              | <input type="checkbox"/> |           |       |    |                 |          |         |        |                 |          |         |        |
|              | <input type="checkbox"/> |           |       |    |                 |          |         |        |                 |          |         |        |
|              | <input type="checkbox"/> |           |       |    |                 |          |         |        |                 |          |         |        |

\*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.

| Patient 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

I, as the undersigned employer or other eligible membership organization duly organized under the laws of the State of Ohio, hereby apply to the carrier(s) offering the coverage indicated on this Application. I acknowledge that by applying for these products, coverage is provided by the following entities (collectively referred to as "Medical Mutual:")

- Medical Mutual of Ohio® (MMO) for non-HMO health plans
- Medical Health Insuring Corporation of Ohio (MHICO) for HMO health plans
- Consumers Life Insurance Company® (CLIC) for life, accidental death and dismemberment, and disability benefits.

These benefits are being offered through the policies issued by Medical Mutual to the Council of Smaller Enterprises (COSE), a division of Greater Cleveland Partnership (GCP). A copy of these policies is available at COSE's office for review.

I understand, acknowledge and agree to the following:

- **This Employer Group Enrollment Application, Participation Agreement and Change Form ("Application") is not a contract for benefits. I should continue my current coverage until I am notified in writing that Medical Mutual has accepted this Application.**
- If this Application is accepted by Medical Mutual, the actual benefits will be specified in the contract(s) held by COSE and that said benefits will take effect on the date specified in a communication from the applicable carrier(s) underwriting my group coverage.
- For all groups, each employee not enrolling must complete the waiver section of the applicable employee application. For groups of 1-50 employees: Each employee applying for any product offered by Medical Mutual must complete **all** sections of the applicable employee application.
- Only my full-time employees are eligible for coverage. All individuals who apply for insurance coverage from Medical Mutual must be full-time, common-law employees, drawing a regular paycheck, whose compensation is reported on IRS Form W-2. Independent contractors are not eligible for coverage. For life and/or disability benefits only, being **Actively at Work** (as described earlier in this Application and defined in the group policy) is a requirement for coverage. If an employee is not **Actively at Work** on the day his coverage would otherwise be effective, the effective date of his life and/or disability coverage will be the date of his return to **Active Work**. If an employee does not return to **Active Work**, he will not be covered.
- To be eligible for coverage, I must comply with all applicable laws of the State of Ohio. By applying for coverage, I agree that Medical Mutual may, from time to time, verify my compliance with the underwriting eligibility or participation standards of the pertinent program. I agree to provide payroll records if requested by Medical Mutual or any other carrier to verify my compliance.
- Any untrue or incomplete information, statements or answers on this Application (whether or not intentional) 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 rescission of coverage for me or any group member, and may subject me or any group member to legal action by Medical Mutual. I have a duty to notify Medical Mutual of any changes to the information contained in this Application.
- Approval and acceptance of this Application and individual employee applications are subject to Medical Mutual's underwriting guidelines, as permitted by law. Checking the boxes does not cause automatic enrollment. Medical Mutual must approve this Application.
- This Application shall be made part of the policy for which application is made and supersedes any previous applications for this group coverage.
- By signing this Application, I represent that this group or company is not an entity that has been formed primarily to obtain insurance coverage, and it does not permit membership in this group or company solely for the purpose of obtaining insurance coverage.
- I authorize Medical Mutual to obtain information from prior carriers to determine existence of pre-existing conditions. Prior carriers are authorized to release such information to Medical Mutual upon receipt of a copy of this Application. Medical Mutual collects this data as a service to you.
- 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 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.
- For life and/or disability coverage, I understand and agree: (1) COSE is not an insurer and has no obligations regarding payment of premium or handling of claims for the life and/or disability insurance provided under the group insurance policy issued to it as policyholder; and (2) upon acceptance and approval by Medical Mutual, I will, so long as such participation continues, fully comply with all obligations applicable to Participating Employers under the policy as set forth therein. I have relied upon no oral or written representations that contradict the aforementioned active-work information.

## 10. Authorized Signature (Please print)

|                                       |                                     |       |
|---------------------------------------|-------------------------------------|-------|
| Business Name                         | Name (print)                        | Title |
| Authorized Signature                  |                                     | Date  |
| Broker Signature (if applicable)      | Broker Name (print) (if applicable) |       |
| Commissions Payable to Federal 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)





