TOLEDO AREA CHAMBER OF COMMERCE

EMPLOYER/GROUP ENROLLMENT APPLICATION & CHANGE FORM

Return completed form to the applicable address:

- for New Group Enrollment
  Cost Center 0121
  Medical Mutual (MM)
  P.O. Box 943
  Toledo, OH 43656-0001

- for Changes to Existing Group Coverage
  Group Services, Inc.
  P.O. Box 94686
  Cleveland, OH 44101-4686

EMPLOYER/GROUP ENROLLMENT APPLICATION/CHANGE FORM

TOLEDO AREA CHAMBER OF COMMERCE

DO NOT CANCEL YOUR CURRENT COVERAGE UNTIL YOU HAVE RECEIVED WRITTEN ACCEPTANCE FROM THE CARRIERS.

1. GROUP/COMPANY INFORMATION

BUSINESS NAME | Chamber Membership #

HAS THIS GROUP EVER BEEN KNOWN BY ANOTHER NAME? ☐ YES ☐ NO IF YES, WHAT NAME(S)?

ADDRESS (No P.O. Boxs) | EMAIL ADDRESS | BILLING ADDRESS

CITY | COUNTY | STATE | ZIP CODE - | BUSINESS PHONE NUMBER ( ) -

CHIEF EXECUTIVE OFFICER | BILLING CONTACT | BUSINESS FAX NUMBER

EMPLOYER/FEDERAL TAX ID # | SIC CODE | NUMBER OF YEARS IN BUSINESS (If less than one year, specify the date the business started.)

TYPE OF BUSINESS (be specific) | E-MAIL ADDRESS

DO YOU HAVE ANY AFFILIATIONS WITH OTHER COMPANIES OR UNIONS (include parent, subsidiary, joint venture, etc...)? ☐ YES ☐ NO
IF YES PLEASE DESCRIBE.

PROPOSED EFFECTIVE DATE FOR COVERAGE TO START / /

2. ENROLLMENT CRITERIA

ELIGIBLE EMPLOYEE DEFINITION:

What is the minimum # of hours to be worked per Week for employees to be considered eligible for Insurance Benefits ______ (Must be between 17.5 and 25 hours)

Probation Period for Insurance Benefits (in days) New Hires ________ Rehires ________

Is the Employer Contribution at least 25% of each contract? ☐ Yes ☐ No

PARTICIPATION	Active*	COBRA	Retired*
Total Number of Current Employees (part time & full time)			
Total Number of Eligible Employees			
Number of Eligible Employees Applying for Coverage			

* Including Owners, Officers and Partners who receive compensation from the company, reported on a tax form other than a 1099.

3. MEDICAL MUTUAL HEALTH INSURANCE PLANS (check appropriate box(es))

	PROGRAM	# OF EMPLOYEES ENROLLING
	SuperMed Plus Multiple Option: ☐ 7 ☐ 7.5 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12	
	Group of One- SuperMed Plus 500/1000 ☐ with maternity ☐ without maternity	
	Medifil	
	High Deductible ☐ SuperMed Plus	
	HSA 2000 ☐ Aggregate ☐ Embedded 2500 ☐ Aggregate ☐ Embedded 3000 ☐ Aggregate ☐ Embedded 4000 ☐ Aggregate ☐ Embedded	
	☐ Prescription Drug Program (Only available in association with the SuperMed products listed above.)	

4. DENTAL PLAN (check appropriate box(es))

Medical Mutual Dental 10+ Employer	PROGRAM	(A)dd (C)hange (D)elete	# OF EMPLOYEES ENROLLING w/medical	
	☐ Traditional		100%	

5. VISION SERVICE PLAN

Programs	# OF EMPLOYEES ENROLLING	EMPLOYER CONTRIBUTION	A-ADD C-CHANGE D-DELETE	PROPOSED EFFECTIVE DATE
☐ Option 1 ☐ Option 2 (25% - 75% Employer Contribution)	100%	100% ☐ Single _____ % ☐ Family _____ %		/ /

6. FORT DEARBORN LIFE INSURANCE COMPANY PLANS

GUARANTEED ISSUE INFORMATION* *Amounts in excess of the Guaranteed Issue are subject to evidence of insurability satisfactory to Fort Dearborn Life	# OF EMPLOYEES ENROLLING	EMPLOYER CONTRIBUTION	A-ADD C-CHANGE D-DELETE	PROPOSED EFFECTIVE DATE
☐ Basic Life and AD&D		_____ %		
☐ Dependent Life		_____ %		/ /
☐ Optional Life (Complete Evidence of Insurability Form)		_____ %		

☐ All Employees $____________each (minimum $10,000, use increments of $5,000)
☐ All Employees ____x Base Annual Earnings* rounded to next higher of $1,000, to a maximum of $__________
☐ Employees according to following Class designation:

*(excluding bonuses, overtime, and other forms of extra pay)

Class	Job Titles/Salary Levels (as indicated on the employee application)	Benefit Amount
1.		
2.		
3.		

☐ Group Short Term Disability* - Maximum weekly benefit $________ (not to exceed $500) **Select One Plan:** ☐ 1-8-26 ☐ 15-15-26 *Benefits may not exceed 70% of Employee's Basic Weekly Income	_____ % Employer Contribution _____ # of Employees Enrolling		/ /

7. CURRENT and PRIOR CARRIER HISTORY (list current carrier first)

List all carriers used for all product lines 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	Single	2-Person	Family	Medicare	Single	2-Person	Family	Medicare
1.											
2.											
3.											

* Examples: Traditional, Comprehensive Major Medical, Self Insured, etc... ** For the current carrier.

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's Disease, Cancer, Diabetes, Heart Attack or Heart Disease, Hemophilia, Kidney Disease, Mental Illness or Substance Abuse?**
☐ YES ☐ NO **If Yes, provide details below.**

PATIENT NAME	AGGREGATE DOLLAR AMOUNT OF CLAIMS	DATES OF SERVICE	DESCRIBE ILLNESS OR CONDITION

B. • **HAS ANYONE WITHIN THE PAST 24 MONTHS been hospitalized, institutionalized or missed work due to any disability or work related injury?** ☐YES ☐NO **If Yes, provide details below.**

PATIENT NAME	DESCRIBE ILLNESS OR CONDITION

C. • **IS ANYONE CURRENTLY COBRA Eligible/Enrolled?** ☐YES ☐NO **If Yes, provide details below.**

NAME	SOCIAL SECURITY #	BEGINNING DATE	EXPIRATION DATE	QUALIFYING EVENT

D. • **ARE THERE ANY RETIREES who meet the eligibility requirements AND are members of a formal retirement program?** ☐YES ☐NO
If Yes, provide details below.

NAME	SOCIAL SECURITY #	AGE AT RETIREMENT	DATE OF RETIREMENT	DATE OF HIRE	AVG. HRS. WORKED PER WEEK PRIOR TO RETIREMENT

9. TERMS and CONDITIONS

1. The group named herein, which is duly organized under the laws of the State of Ohio, hereby applies to the carriers for the benefits selected herein. The group understands and acknowledges if this application is accepted by the carrier(s) selected herein, that the actual benefits will be specified in the contract(s) held by the association responsible for offering these benefit options and that said benefits will take effect on the date specified in a letter that will be forwarded directly from the carrier(s) underwriting the coverage to the group. **This Employer/Group Enrollment Application is not a contract for health care benefits. Continue your current coverage until you are notified in writing that the carrier has accepted this application.**
2. For Groups 1-24 members: each employee applying for Medical Mutual Traditional or SuperMed coverage must complete all sections of the EMPLOYEE APPLICATION, CHANGE FORM AND MEDICAL HISTORY QUESTIONNAIRE (Sections 1 - 9).
3. To be eligible for coverage an individual must be a full time employee of the group or company applying for coverage. All individuals who apply for insurance coverage from the carriers must be full-time common law employees, drawing a regular paycheck, whose compensation is reported on IRS Form W-2. Independent contractors to the group or company are not eligible for coverage.
4. To be eligible for coverage, the group or company must be in compliance with all applicable laws of the State of Ohio.
5. Any untrue or incomplete information, statements or answers on this application (whether intentional or not) or engaging in any fraudulent conduct, deceptions or misrepresentation relating to any application, coverage, claim or usage of a carrier identification card, can result in denial of a claim or recision of coverage for the group or any group member, and may subject the group or any group member to legal action by the carrier.
6. Approval and acceptance of this Employer/Group Enrollment Application and individual Employee Applications are subject to the carrier's underwriting guidelines.
7. It is agreed that this Employer/Group Enrollment Application supersedes any previous applications for this group coverage.
8. By signing this Employer/Group Enrollment Application the authorized representative of the group or company represents that the group or company is not an entity that has been formed primarily to obtain insurance coverage and it does not permit membership in the group or company solely for the purpose of obtaining insurance coverage.
9. For all groups: Each employee not enrolling must complete the Waiver on the cover page of the EMPLOYEE APPLICATION, CHANGE FORM AND MEDICAL HISTORY QUESTIONNAIRE.
10. The group hereby authorizes the carrier(s) to obtain information from prior carriers to determine existence of pre-existing conditions. Prior carriers are authorized to release such information to the carrier(s) upon receipt of a copy of this application.
11. I understand: and agree that no agent or broker has the authority: (1) to bind Medical Mutual by making promises regarding eligibility, benefits, or the issuance of a policy; (2) to waive any answer or any portion of any answer to any question on this application or any information Medical Mutual requests; (3) approve coverage; (4) make or alter any contract on behalf of Medical Mutual; or (5) waive or alter any of Medical Mutual's other rights or requirements. All contract terms must be in writing and signed or accepted in writing by an authorized representative of Medical Mutual to be binding on Medical Mutual.
12. GSI collects this data as a service to you. Checking the boxes does not cause automatic enrollment. The Insurance Carrier(s) must approve this application.

10. AUTHORIZED SIGNATURES

GROUP NAME	NAME (print)	TITLE
SIGNATURE		DATE
AGENT		AGENT PHONE #

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)