MEDICAL MUTUAL OF OHIO®
YOUR HEALTHCARE PARTNER SINCE 1934

SuperMed One®

CONSUMERS LIFE INSURANCE COMPANY®
A MEDICAL MUTUAL OF OHIO COMPANY

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 ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐	Marriage Date: / /	Divorce Date: / /

Permanent Residence	City	E-mail Address

County	State	Zip Code	Best Contact # ( )	Alternate # ( )

Reason for Application: Applying for new coverage ☐ Applying for change to current coverage ☐ Applying for dependent only coverage ☐ Adding dependent ☐

	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

Elite Plans w/Office Copay
- ☐ $500/$1000
- ☐ $1000/$2000
- ☐ $1500/$3000
- ☐ $2500/$5000

Elite Plans w/o Office Copay
- ☐ $2500/$5000
- ☐ $5000/$10000
- ☐ $10000/$20000

Optional Riders
- ☐ Maternity Services
- ☐ Dental
- ☐ Vision
- ☐ Life (complete sections III & IV)

Premium Plans w/Office Copay
- ☐ $500/$1000
- ☐ $1000/$2000
- ☐ $1500/$3000
- ☐ $2500/$5000

Optional Riders
- ☐ Maternity Services
- ☐ Dental
- ☐ Vision
- ☐ Life (complete sections III & IV)

Wellness HSA
- ☐ $1500/$3000
- ☐ $2500/$5000
- ☐ $3000/$6000
- ☐ $5000/$10000

Value Plans
- ☐ $500/$1000
- ☐ $1000/$2000
- ☐ $1500/$3000

Optional Riders
- ☐ Dental
- ☐ Vision
- ☐ Life (complete sections III & IV)

Ancillary Coverage[1]
- ☐ Dental
- ☐ Vision

[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

☐ $10,000

Do 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

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
1. Abnormal Pap Smears	☐	☐
2. Allergies	☐	☐
3. Alzheimer's Disease	☐	☐
4. Anemia (Type: _____)	☐	☐
5. Aneurysm	☐	☐
6. Anorexia/Bulimia	☐	☐
7. Arthritis (Type: _____)	☐	☐
8. Asthma	☐	☐
9. Back Sprains/Strains	☐	☐
10. Bronchitis	☐	☐
11. Bursitis	☐	☐
12. Cancer (Type: _____)	☐	☐
13. Cardiomyopathy	☐	☐
14. Carotid Artery Disease	☐	☐
15. Carpel Tunnel Syndrome	☐	☐
16. Cataracts	☐	☐
17. Cerebral Palsy	☐	☐
18. Cholesterol (High)	☐	☐
19. COPD or Emphysema	☐	☐
20. Cirrhosis of the Liver	☐	☐
21. Colitis (Including Ulcerative)	☐	☐
22. Colon Polyps	☐	☐
23. Congenital Disorders	☐	☐
24. Congestive Heart Failure	☐	☐
25. Coronary Artery Disease (Including Angina and Angioplasty)	☐	☐
26. Coronary Insufficiency	☐	☐
27. Crohns Disease	☐	☐
28. Cystic Fibrosis	☐	☐
29. Cystitis (Chronic or interstitial)	☐	☐
30. Cysts, Tumors or Growths	☐	☐
31. Diabetes/ Blood Sugar Disorder Last 3 Blood Sugars & Dates: 1) _____ 2) _____ 3) _____	☐	☐

CONDITION	YES	NO
32. Diverticulitis/Diverticulosis	☐	☐
33. Down's Syndrome	☐	☐
34. Drug/Alcohol Abuse (Including Arrests/ Convictions)	☐	☐
35. Endometriosis	☐	☐
36. Fibrocystic Breast Disease	☐	☐
37. Fibromyalgia	☐	☐
38. Gallbladder Disease	☐	☐
39. Gastric Reflux (GERD)	☐	☐
40. Gastric Bypass / Banding	☐	☐
41. Gout	☐	☐
42. Graves Disease	☐	☐
43. Growth Deficiency	☐	☐
44. Heart Attack	☐	☐
45. Heart Bypass Grafting	☐	☐
46. Heart Murmur	☐	☐
47. Heart Palpitations/ Arrhythmia	☐	☐
48. Heart Valve Disorders	☐	☐
49. Hemorrhoids	☐	☐
50. Hemophilia	☐	☐
51. Hydrocephalus/Shunt	☐	☐
52. Hypertension (High Blood Pressure) Last 3 Pressures & Dates: 1) _____ 2) _____ 3) _____	☐	☐
53. Ileostomy/Colostomy	☐	☐
54. Infertility	☐	☐
55. Irritable Bowel Syndrome	☐	☐
56. Joint Replacement	☐	☐
57. Kidney Failure	☐	☐
58. Kidney Stones	☐	☐
59. Liver Disorders/Hepatitis	☐	☐
60. Lou Gehrig's Disease (ALS)	☐	☐
61. Meningitis	☐	☐
62. Menstrual Disorders (including Abnormal Cycles/Uterine Bleeding)	☐	☐

CONDITION	YES	NO
63. Mental Health Disorders (Including Depression, Anxiety, ADD/ADHD and counseling)	☐	☐
64. Migraines	☐	☐
65. Multiple Sclerosis	☐	☐
66. Muscular Dystrophy	☐	☐
67. Organ Transplant/Failure	☐	☐
68. Osteoporosis	☐	☐
69. Otitis Media (ear infections)	☐	☐
70. Ovarian Cyst/Polycystic Ovarian Disease	☐	☐
71. Pacemaker Implantation	☐	☐
72. Pancreatitis	☐	☐
73. Paralysis	☐	☐
74. Parkinson's Disease	☐	☐
75. Peptic/Gastric Ulcer	☐	☐
76. Peripheral Vascular Disease	☐	☐
77. Phlebitis/Blood Clot	☐	☐
78. Polycystic Kidney Disease	☐	☐
79. Prostate Disorders	☐	☐
80. Schizophrenia/Bipolar	☐	☐
81. Scleroderma	☐	☐
82. Seizure Disorder/Epilepsy	☐	☐
83. Sexually Transmitted Disease	☐	☐
84. Skin Conditions (includes Acne, Psoriasis, Rosacea, Nail Fungus, Eczema)	☐	☐
85. Sleep Apnea	☐	☐
86. Spina Bifida Cystica/Occulta	☐	☐
87. Spinal Disorders/ Disc Disease	☐	☐
88. Stroke	☐	☐
89. Suicide Attempts/ Psych Admits	☐	☐
90. Systemic Lupus	☐	☐
91. Tendonitis	☐	☐
92. Thyroid Disorder	☐	☐
93. TMJ	☐	☐
94. Tonsillitis	☐	☐
95. Transient Ischemic Attacks (TIA)	☐	☐
96. Varicose Veins	☐	☐

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

If any Medical Eligibility questions (B, C1-C96, D, E) are checked "YES", please explain below, (use additional paper, if necessary). Indicate all details of the injury, ailment or condition. Include items such as specific location of condition (example: right knee), diagnosis, type of treatment and hospitalization.

QUESTION NUMBER	PATIENT FIRST NAME	DETAILS OF CONDITION AND CURRENT STATUS	MEDICATION DOSAGE AND DATES USED	HOSPITALIZED OR SURGERY?	PHYSICIAN NAME	TREATMENT DATES
EXAMPLE: H18	*Mark*	*High cholesterol controlled by medication. Current LDL < 170.*	*Crestor 20 mg/day 9/2002 to current*	*No*	*Dr. John Doe*	*6/02 – 9/04*

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)

☐ 1. Friend/Family Member
☐ 2. Yellow Pages
☐ 3. Insurance Agent
☐ 4. Advertisement in newspaper, magazine, etc.
☐ 5. Newspaper Article
☐ 6. Internet/Web site
☐ 7. Radio
☐ 8. Mail
☐ 9. Through current employer
☐ 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		Agent of Record	Tax I.D.
Service — Account Executive and Code	**or**	Royal Advantage® Broker	Commission Indicator