HEALTH AND LIFE APPLICATION / POLICY CHANGE

GROUP # | SECTION

1. (Please Print) ABOUT YOU AND YOUR JOB...

YOUR LAST NAME | YOUR SOCIAL SECURITY NUMBER | COMPANY NAME/EMPLOYER

YOUR FIRST NAME | M.I. | YOUR DATE OF BIRTH / / | SEX (M or F) | OCCUPATION/JOB TITLE | EMPLOYEE/CLOCK #

YOUR STREET ADDRESS | DEPARTMENT NAME | PAYROLL LOCATION/DEPT. #

CITY | STATE | ZIP CODE | FULL TIME DATE OF (RE)HIRE / / | EMPLOYMENT STATUS ☐ACTIVE ☐RETIRED ☐COBRA

HOME PHONE NUMBER ( ) - | MARITAL STATUS: ☐SINGLE ☐MARRIED ☐SEPARATED ☐DIVORCED ☐WIDOWED | DATE MARRIED / / | BUSINESS PHONE ( ) - EXT. | COBRA EXPIRATION DATE / /

2. (Please Print) WHAT YOU WANT DONE...

A) NEW POLICY APPLICATION

1. Type of Coverage:
   PRIMARY COVERAGE: (check only one)
   ☐ Traditional ☐ SuperMed Classic ☐ SuperMed Plus
   ☐ HMO Health Ohio℠ ☐ SuperMed HMO ☐ SuperMed Select
   ADDITIONAL COVERAGE(S): (check all that apply) ☐ Drug ☐ Dental ☐ Vision ☐ Life only
2. Who Do You Want Covered?
   ☐ You Only ☐ You and One Other Person ☐ You and Your Family
   Medicare Supplement For: ☐ You ☐ Spouse ☐ Dependent

B) CHANGE TO AN EXISTING POLICY

1. Date of Change: ___/___/___ 2. Requested Effective Date: ___/___/___
3. Action (Check the Type of Change)
   ☐ ADD DEPENDENT TO POLICY (LIST DEPENDENTS IN SECTION 3 BELOW)
   ☐ DELETE DEPENDENT FROM POLICY (LIST DELETED DEPENDENTS IN SECTION 3 BELOW)
   ☐ BENEFIT CHANGE (INDICATE CHOICE TO THE IMMEDIATE LEFT UNDER SECTION A)
   ☐ PRIMARY CARE PHYSICIAN/LOCATION CHANGE (INDICATE CHANGE IN SECTION 3 BELOW)
   ☐ NAME CHANGE: FORMER NAME: _____
   ☐ TERMINATED EMPLOYMENT ☐ DECEASED
   ☐ REQUESTED CANCELLATION ☐ OTHER: _____

3. (Please Print) ABOUT YOU AND YOUR DEPENDENTS...

A.	(A)dd (C)hange (D)elete	Name FIRST NAME	LAST NAME (IF DIFFERENT)	Social Security #	Date of Birth	Sex M or F	(C)HILD (S)TEPCHILD (O)THER*	Primary Care Physician	Current Patient
SELF									Yes ☐ No ☐
Spouse				- -	- -				Yes ☐ No ☐
1				- -	- -				Yes ☐ No ☐
2				- -	- -				Yes ☐ No ☐
3				- -	- -				Yes ☐ No ☐
4				- -	- -				Yes ☐ No ☐

*ATTACH LEGAL DOCUMENTS

4. MEDICAL QUESTION...

HAVE YOU OR ANY OF YOUR DEPENDENTS EVER BEEN TREATED FOR A SERIOUS MEDICAL CONDITION SUCH AS HEART DISEASE, CANCER, DIABETES, TRANSPLANTS, NERVOUS SYSTEM AND MUSCLE DISORDER, AIDS OR AIDS RELATED COMPLEXES OR MENTAL DISORDERS?
YES ☐ NO ☐ **IF YES ... MUST PROVIDE EXPLANATION OF CONDITION AND INCLUDE ANY PRESCRIBED MEDICATIONS.**

5. (Please Print) ABOUT YOUR OTHER HEALTH INSURANCE AND MEDICARE...

What date did your most recent health insurance or health benefit program become effective (check box if no prior/current coverage)? / / ☐ No Coverage

What date did/will the above health insurance or health benefit program terminate? / /

DO YOU OR ANY OF YOUR DEPENDENTS HAVE ANY OTHER HEALTH OR DENTAL COVERAGE? ☐ YES ☐ NO **IF YES, COMPLETE THE SECTION BELOW.**

NAME OF POLICY HOLDER	NAME AND ADDRESS OF OTHER INSURANCE COMPANY	POLICY NUMBER	EFFECTIVE DATE	COVERAGE TYPES	WORK STATUS	POLICY TYPE
			/ /	☐ Medical ☐ Dental ☐ Hospital Only ☐ Vision ☐ Prescription Drug	☐ Active ☐ Retired	☐ Single ☐ Family

MEDICARE INFORMATION:
Are you covered by Medicare? ☐ YES ☐ NO If YES, Medicare No. _____ EFFECTIVE DATE: PART A: / / PART B: / / ☐ Hemodialysis
Is your spouse or dependent covered by Medicare? ☐ YES ☐ NO If YES, Medicare No. _____ EFFECTIVE DATE: PART A: / / PART B: / / ☐ Hemodialysis

6. (Please Print) ABOUT YOUR LIFE AND DISABILITY INSURANCE...

IF YOUR EMPLOYER OFFERS ANY OF THE FOLLOWING COVERAGES, PLEASE INDICATE IF YOU WOULD LIKE TO ENROLL IN ANY OF THESE COVERAGES AND THE AMOUNT.

BASIC LIFE	DEPENDENT LIFE	SUPPLEMENTAL LIFE	SUPPLEMENTAL AD&D	SHORT TERM DISABILITY	LONG TERM DISABILITY
☐ YES ☐ NO	☐ YES ☐ NO	☐ YES (AMT. $) ☐ NO	☐ YES (AMT. $) ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

IF ANY YES BOX IS CHECKED ABOVE, COMPLETE THE REMAINDER OF THIS SECTION.

GROUP/DIVISION NUMBER: | CLASS: | SALARY $ ☐ HOURLY ☐ WEEKLY ☐ MONTHLY ☐ ANNUAL | FOR MLI USE ONLY EFFECTIVE DATE: ___/___/___

Beneficiary Last Name	Beneficiary First Name	Date of Birth	Relationship	Benefit Split**
PRIMARY				%
SECONDARY				%

** Unless otherwise noted, if two primary beneficiaries are named, the proceeds will be paid in equal shares to the primary beneficiaries surviving you.

7. SIGNATURES - Sign after completing and reading all applicable sections (including front of this application).

I have read all of the statements contained in this application, and declare by signing this application that I am an active, eligible, compensated, full-time employee and that the information I have provided is true and complete to the best of my knowledge. Signature of Spouse authorizes release of information described on the front of this application.

_____ Date