



CONSUMERS LIFE
INSURANCE COMPANY®
A MEDICAL MUTUAL OF OHIO COMPANY

Employer/Group Enrollment Application & Change Form

CLIC 2-99 Eligible Employees

THIS IS AN APPLICATION FOR COVERAGE, NOT A CONTRACT.

DO NOT CANCEL YOUR CURRENT COVERAGE UNTIL YOU HAVE RECEIVED WRITTEN ACCEPTANCE FROM
CONSUMERS LIFE INSURANCE COMPANY, A MEDICAL MUTUAL OF OHIO® COMPANY.

NOTE: If your group is accepted, Consumers Life cannot provide retroactive effective dates.



EMPLOYER GROUP ENROLLMENT APPLICATION/CHANGE FORM CLIC 2-99 ELIGIBLE EMPLOYEES

initial enrollment change

1. Group/Company Information

Business Name					
Has this business ever been known by another name? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what name(s)?					CLIC Membership # (if applicable)
Business Address (No P.O. Boxes)			Billing Address		
City	County	State	Zip Code	Business Phone Number	
Chief Executive Officer		Billing Contact		Business Fax Number	
Business E-Mail			Number of years in business (If less than one year specify the date the business started.)		
Type of Business (be specific)		SIC Code	Employer/Federal Tax ID #		
Do you have any affiliations with other companies or unions (include parent, subsidiary, joint venture, etc...)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe.					Dun and Bradstreet #
If yes, do any of these affiliates qualify as a single employer under subsection (b), (c), (m), or (o) of the Internal Revenue Code Section 414? If yes, please give the legal names, federal tax ID# and number of employees.					Has group ever applied with MMO and/or CLIC? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, when?
					Is the employer contribution at least 25% of each contract? <input type="checkbox"/> Yes <input type="checkbox"/> No

2. Enrollment Criteria

Eligible Employee: State minimum # of hours to be worked per week for employees to be considered eligible for insurance benefits. (Minimum must be between 30 hours and 40 hours per week for full time eligibility for groups with 50 or fewer eligible employees.) _____

Waive probationary period for initial enrollment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Probation Period for New Hire Benefits <input type="checkbox"/> Date of Hire <input type="checkbox"/> 30 days following Date of Hire <input type="checkbox"/> 60 days following Date of Hire <input type="checkbox"/> 90 days following Date of Hire <input type="checkbox"/> 180 days following Date of Hire	<input type="checkbox"/> First of month following Date of Hire <input type="checkbox"/> First of month following 30 days <input type="checkbox"/> First of month following 60 days <input type="checkbox"/> First of month following 90 days	Probation Period for Rehires <input type="checkbox"/> Same as Probationary Period for New Hires <input type="checkbox"/> Other _____
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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 other than a 1099.

Multiple Facilities: Do you have facilities in multiple locations? (Only applicable if applying for coverage) Yes No If yes, list where and employee counts.

City and State	Total Number of Employees	Total Number of Applicants

3. Health and Prescription Plans

Group Size	SuperMed Plus®:	P2580-500	P3080-1000	P30100-1000	P4080-500	Proposed Effective Date
2+		<input type="checkbox"/> P25100-500	<input type="checkbox"/> P3080-1500 <input type="checkbox"/> P3080-2000 <input type="checkbox"/> P3080-2500 <input type="checkbox"/> P3080-3000 <input type="checkbox"/> P3080-5000	<input type="checkbox"/> P30100-1500 <input type="checkbox"/> P30100-2000 <input type="checkbox"/> P30100-2500 <input type="checkbox"/> P30100-3500 <input type="checkbox"/> P30100-5000	<input type="checkbox"/> P4080-1000 <input type="checkbox"/> P4080-1500 <input type="checkbox"/> P4080-2000 <input type="checkbox"/> P4080-2500 <input type="checkbox"/> P4080-3000 <input type="checkbox"/> P4080-5000	
2+	Vital Access:	<input type="checkbox"/> P2580-3500 <input type="checkbox"/> P2580-5000 <input type="checkbox"/> P2580-7500 <input type="checkbox"/> P2580-10000	<input type="checkbox"/> P25100-3500 <input type="checkbox"/> P25100-5000 <input type="checkbox"/> P25100-7500 <input type="checkbox"/> P25100-10000			
	Prescription Drug Options:	<input type="checkbox"/> Option 1	<input type="checkbox"/> Option 2	<input type="checkbox"/> Option P4		
2+	High Deductible Health Plans: (HSA Compatible Plans):	<input type="checkbox"/> P2500 <input type="checkbox"/> P2500 Value	<input type="checkbox"/> P3000 <input type="checkbox"/> P3000 Value	<input type="checkbox"/> P4000 <input type="checkbox"/> P4000 Value	<input type="checkbox"/> P5000 <input type="checkbox"/> P5000 Value	
	<input type="checkbox"/> I hereby certify that this health plan will be maintained in connection with a health savings account established in accordance with the applicable provisions of the Internal Revenue Code.					
51+	<input type="checkbox"/> Other (NBR Required) _____					
2+	<input type="checkbox"/> Medicare Carveout					

4. Dental and Vision Plans

2+/10+	<input type="checkbox"/> Dental
2+	<input type="checkbox"/> SuperMed® Vision Plan E

5. 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. (list current carrier first)

Carrier Name	Continuing Coverage Yes <input type="checkbox"/> No <input type="checkbox"/>	Benefits*	Dates		Current Rates**				Renewal Rates**			
			From	To	Employee	& Spouse	& Child	Family	Employee	& Spouse	& Child	Family
	Yes <input type="checkbox"/> No <input type="checkbox"/>											
	Yes <input type="checkbox"/> No <input type="checkbox"/>											
	Yes <input type="checkbox"/> No <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.

6. Validations

Groups completing the Employer Risk Assessment Form may skip Sections A & B.

A. Has anyone within the past 24 months missed work due to any disability or work related injury?

Yes No If yes, provide details below.

Patient Name	Describe Illness or Condition

B. Is anyone currently COBRA eligible/enrolled?

Yes No If yes, provide details below.

Name	Social Security #	Beginning Date	Expiration Date	Qualifying Event

C. 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

7. Life and Disability Plans

Life, Accidental Death & Dismemberment, Dependent Life and Short-Term Disability

If the Company approves this application, a policy will be issued. The applicant agrees that acceptance of the Policy will be approval of the policy terms.

Proposal number _____ is incorporated by reference in and made part of this application for all purposes.

If multiple plans are indicated on the proposal, indicated plan number elected _____

If participation-free, voluntary coverages are being elected, please indicate below:

Yes, I am electing participation-free Voluntary Life and Accidental Death and Dismemberment

Yes, I am electing participation-free Voluntary Life and Accidental Death and Dismemberment, and short-term disability

If participation-free, voluntary short-term disability is elected, indicate the plans: 1/8/13 1/8/26

Waiting period is identical to medical probationary period, unless indicated below:

None

First of month following completion of _____ days

Other _____

Employees working less than **20 hours** per week are not eligible for coverage. If different than 20 hours, please indicate number of hours: _____

Employer contribution percentages (%) for all products are as stated in the proposal, unless indicated below:

Group Long-Term Disability

If the Company approves this application, a policy will be issued. The applicant agrees that acceptance of the policy will be approval of the policy terms.

Proposal number _____ is incorporated by reference in and made part of this application for all purposes.

Prior Carrier: _____

(Prior carrier must be listed and a copy of the prior policy included for **continuity of coverage** to apply.)

Termination Date of prior policy: _____

Waiting period – present employees: _____

Waiting period – future employees: _____

Employees working less than 30 hours per week are not eligible for coverage.

If different than 30 hours, please indicate number of hours: _____

Contribution:

Employer _____% Employee _____% Pre-tax dollars Post-tax dollars

8. Terms and Conditions

1. The group named herein, hereby applies to Consumers Life Insurance Company (CLIC), a Medical Mutual of Ohio Company® for the benefits selected herein. The group understands and acknowledges that the actual benefits will be specified in the group contract if this application is accepted by CLIC, and that benefits will take effect as of the date specified in such group contract. **This Employer/Group Enrollment Application is not a contract for healthcare benefits. Continue your current coverage until you are notified in writing that CLIC has accepted this application.**
2. For all groups: Each employee not enrolling must complete the Waiver on the cover page of the Employee Application and Change Form and Medical History Questionnaire. For groups with 2 - 50 members: Each employee enrolling must complete all sections of the Employee Application and Change Form and Medical History Questionnaire (Sections 1 - 8).
3. To be eligible for coverage, an individual must be a full time employee of the group or company applying for coverage. Any individual who applies for insurance coverage from CLIC must be a full-time common law employee, drawing a regular paycheck and with compensation reported on IRS Form W-2. Independent contractors of the group or company are not eligible for coverage.
4. To be eligible for coverage by CLIC, the group or company must be in compliance with all applicable state and federal laws.
5. Any untrue or incomplete information, statements or answers on this application (whether intentional or not) or engaging in any fraudulent conduct, deception or misrepresentation relating to any application, coverage, claim or usage of a CLIC identification card can result in denial of a claim or rescision of coverage for the group or any group member, and may subject the group or any group member to legal action by CLIC.
6. Approval and acceptance of this Employer/Group Enrollment Application and individual Employee Applications are subject to CLIC underwriting guidelines; including contribution and participation requirements.
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 health insurance coverage, and it does not permit membership in the group or company solely for the purpose of obtaining health insurance coverage.
9. The group hereby authorizes CLIC to obtain information from prior carriers to determine existence of pre-existing conditions. Prior carriers are authorized to release such information to CLIC upon receipt of a copy of this application.
10. I understand and agree that no agent or broker has the authority: (a) to bind CLIC by making promises regarding eligibility, benefits, or the issuance of a policy; (b) to waive any answer or any portion of any answer to any question on this application or any information CLIC requests; (c) approve coverage; (d) make or alter any contract on behalf of CLIC; or (e) waive or alter any of CLIC's other rights or requirements. All contract terms must be in writing and signed or accepted in writing by an authorized representative of CLIC to be binding on CLIC.

9. Authorized Signature (Please print)

Business Name	Name (print)	Title
Authorized Signature	Date	
Broker Signature (if applicable)	Broker Name (print) (if applicable)	
Federal Tax ID	Royal Advantage Broker	

WARNING: Any person who knowingly and with intent to defraud and insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which is a crime and subjects such persons to criminal and civil penalties.

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Consumers Life Insurance Company®
2060 East Ninth Street
Cleveland OH 44115-1355