



CONSUMERS LIFE  
INSURANCE COMPANY®  
A MEDICAL MUTUAL OF OHIO® Company

# Employer/Group Enrollment Application & Change Form

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CLIC 2-99 Eligible Employees

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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.**



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	Probationary 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	Probationary 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®	Proposed Effective Date
2+	<input type="checkbox"/> 2580-500 <input type="checkbox"/> 3080-1000 <input type="checkbox"/> 30100-1000 <input type="checkbox"/> 4080-500 <input type="checkbox"/> 25100-500 <input type="checkbox"/> 3080-1500 <input type="checkbox"/> 30100-1500 <input type="checkbox"/> 4080-1000 <input type="checkbox"/> 3080-2000 <input type="checkbox"/> 30100-2000 <input type="checkbox"/> 4080-1500 <input type="checkbox"/> 3080-2500 <input type="checkbox"/> 30100-2500 <input type="checkbox"/> 4080-2000 <input type="checkbox"/> 3080-3000 <input type="checkbox"/> 30100-3500 <input type="checkbox"/> 4080-2500 <input type="checkbox"/> 4080-3000	
	Prescription Drug Options: <input type="checkbox"/> Option 1 <input type="checkbox"/> Option 2 <input type="checkbox"/> Option 3 <input type="checkbox"/> Option 4	
2+	High Deductible Health Plan Options: <input type="checkbox"/> SMP 2200 <input type="checkbox"/> SMP 3000 <input type="checkbox"/> SMP 5000 (HSA) Compatible Plans <input type="checkbox"/> SMP 2500 <input type="checkbox"/> SMP 4000 <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

Contributions: Life/Accidental Death & Dismemberment <input type="checkbox"/> 100% <input type="checkbox"/> Other _____ % Short Term Disability <input type="checkbox"/> 100% <input type="checkbox"/> Other _____ % Long Term Disability <input type="checkbox"/> 100% <input type="checkbox"/> Other _____ % Dependent Life <input type="checkbox"/> 100% <input type="checkbox"/> Other _____ % Other <input type="checkbox"/> 100% <input type="checkbox"/> Other _____ %	Waiting Period (if different from medical) <input type="checkbox"/> None <input type="checkbox"/> First of the month following completion of _____ days <input type="checkbox"/> Other _____	Proposed Effective Date
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### Schedule of Benefits

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

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

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

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

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

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

Class	<input type="checkbox"/> Basic Life Insurance Amount of Insurance	<input type="checkbox"/> Basic Accidental Death & Dismemberment Principal Sum	<input type="checkbox"/> Supplemental Life Amount of Insurance	<input type="checkbox"/> Supplemental Accidental Death & Dismemberment Principal Sum	<input type="checkbox"/> Short Term Disability Weekly Maximum
1	_____	_____	_____	_____	_____
2	_____	_____	_____	_____	_____
3	_____	_____	_____	_____	_____
4	_____	_____	_____	_____	_____

1. Weekly Short Term Disability benefit is subject to a maximum of \_\_\_\_\_ % of employee's Basic Weekly Wage.
2. Short Term Disability Benefits Payable: \_\_\_\_\_ day of Accident; \_\_\_\_\_ day of Sickness for a maximum benefit period of \_\_\_\_\_ weeks.
3. 1st day Hospital?  Yes  No
4. Short Term Disability Benefits payable for non-occupational disabilities only.
5. All benefits terminate at retirement unless otherwise noted in class definition section.
6. Short Term Disability Benefits not available for employees working in CA, HI, NJ, NY, PR or RI.
7. Life or Accidental Death & Dismemberment benefits include 24 hour coverage.
8. If Life or Accidental Death & Dismemberment 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 Accidental Death & Dismemberment 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 \_\_\_\_\_.
10. Supplemental Life and Accidental Death & Dismemberment 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 \_\_\_\_\_.

#### Long Term Disability

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 an approval of the policy terms.

Long Term Disability Proposal Number: \_\_\_\_\_

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: \_\_\_\_\_

## 7. Life and Disability Plans (continued)

### Long Term Disability (continued)

#### Eligibility Information:

Define Service Waiting Period – Present Employees:

\_\_\_\_\_

Define Service Waiting Period – Future Employees:

\_\_\_\_\_

Define Eligibility Requirements:

\_\_\_\_\_

Define Premium Contribution:

Employer \_\_\_\_\_% Employee \_\_\_\_\_%  Pre-Tax Dollars  Post-Tax Dollars

Definition of Earnings Include:

BAE: \_\_\_\_\_ Commissions \_\_\_\_\_ Bonuses: \_\_\_\_\_ Overtime \_\_\_\_\_ Other \_\_\_\_\_

### Dependent Life Insurance

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

Child(ren): \$ \_\_\_\_\_ Live birth but less than 15 days

\$ \_\_\_\_\_ Age 15 days but less than 6 months

\$ \_\_\_\_\_ Age 6 months but less than 19 year

\$ \_\_\_\_\_ Age 19 years but less than \_\_\_\_\_, if full time student(s) and dependent upon the insured for support

### 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: \$ \_\_\_\_\_

Short Term Disability: \$ \_\_\_\_\_ Other: \$ \_\_\_\_\_

### D. General Conditions

It is understood and agreed that this application shall be made part of the Policy for which application is made. It is further understood:

1. Being **Actively at Work** 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 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.

The terms "Actively at Work" and "Active Work" mean that an employee is performing the Material and Substantial Duties of his occupation; is working the number of hours specified in Part 7A, Schedule of Benefits; and satisfies any other conditions required by the applicable group Policy.

2. This insurance is subject to the approval of Consumers Life Insurance Company, and nothing contained herein shall be binding upon Consumers Life until this application is approved and accepted at Consumers Life's home office.

3. No waiver or change will bind Consumers Life unless signed by an Executive Officer of Consumers Life.

4. 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: (attached a signed dated sheet if more space is needed)

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

Reason not Actively at Work:  Disability  Family Leave  Other

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

Reason not Actively at Work:  Disability  Family Leave  Other

## 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 rescission 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.

# Employer/Group Enrollment Application & Change Form

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**Consumers Life Insurance Company**

2060 East Ninth Street  
Cleveland OH 44115-1355

Visit [ConsumersLife.com](http://ConsumersLife.com).