

1975 Tamarack Road P.O. Box 1009 Newark, OH 43058-1009 (800) 423-3151 WARNING: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statements is guilty of insurance or health care fraud under state and/or federal law.

| New Application Only | | | | | | |
|----------------------|--|--|--|--|--|--|
| Coverages Elected | | | | | | |
| Medical | | | | | | |
| Dental | | | | | | |
| Vision | | | | | | |
| LTD | | | | | | |
| Life/AD & D | | | | | | |

| | _ | | VERED MEDICAL LIVES) | |
|---|----------------------------|---------------------|---|---|
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| | | | | ION. IF YOU ARE APPLYING |
| FOR SPOUSAL COVERAC | GE, HAVE YOUR SP | OUSE SIGN AND | DATE THE AGREEMENT | AND AUTHORIZATION. |
| Employee Information (Plea | ase print in ink): | | | Social Security Number |
| Name | First | | Middle Initial | |
| Home Address | FIISL | | | Telephone () |
| Tiomo / taarooo | Street | Dity St. | ate Zip | |
| Employee Date of Birth | Sex 🔲 Male | Marital Status | Who Is to Be Insured | Date Hired// |
| /_/ | ☐ Female | Married | Life Only Coverage | Mo. Day Yr. |
| Mo. Day Yr. | _ | Divorced | ☐ Employee Only | |
| Earnings \$ | Height | ☐ Widowed | ☐ Employee and Spouse | e COBRA Election Date |
| Yearly Weekly | | Single | Employee and Childre | en// |
| | Weight | Common | Employee, Spouse & | Mo. Day Yr |
| Monthly | | Law* | Children | |
| Employed byCompany Na | | | City, State of Employment | Group/Account Number |
| | | | | |
| Occupation | | | | Worked Weekly |
| Beneficiary Name | Last | First | Relationsh | nip |
| * Complete Supplemental I | | | | |
| , , , , | | | E – WAIVER OF COVERA | GE |
| | | | included in the employer's p | · |
| | | | your spouse) because you ha | ave other health insurance tyou request enrollment within 30 |
| days after your other coverage | e ends. In addition, if yo | ou have a new dep | endent as a result of marriage, | birth, adoption, placement for |
| | | | nroll yourself and/or your depe of legal guardianship, or 31 day | endents, provided that you request vs of a birth, adoption, or |
| placement for adoption. This | plan will also allow enro | ollments as necessa | ary to comply with the terms of | medical child support orders, or |
| | | | ederal law. Other than as deso subject to an additional waiting | cribed above, you may not be g period, beginning with the date of |
| late enrollment. | | • | | |
| | erages except emplo | byee only group t | erm life insurance. (Emplo | yee signature required on |
| reverse.) | N. I. O.W. N. O. | (6) | – | |
| I — _ ' | _ | • | | ture required on reverse.) |
| All Dental Coverage | _ ` | ent Medical Cove | · <u>-</u> · | t Vision Coverage |
| All Vision Coverage | e 🔲 All Depend | ent Dental Cover | age 🔲 Other | |
| | COMPLETE FOR D | EPENDENT CO | VERAGE, including SPOU | SE |
| ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | or AD&D or Disability Insurar | |
| - | | 1 | se complete the Waiver of Co | |
| Spouse Name | Date of Birt | h Height/ V | Veight S.S. Nu | umber Male or Female |
| | | | | |
| Spouse employed? Yes | s 🔲 No 🏻 If "Yes", e | mployed by | | Date of Marriage: |
| Spouse insured elsewhere | ? 🔲 Yes 🔲 No If | "Yes", insured b | У | Policy Number: |

| Dependent Children: | | | | Male or | Full-Time | You and/or your spouse | Relatio Natural | nship (Che | Step- | Custody or |
|--|--|--|--|--|--|--|--|--|---|--|
| Full Name | Da | ate of Birth | Height/ Weight | Female | Student? (Y/N) | provide over 50% support? | Child | Child* | Child | Guardian-sh |
| | | | | | | | | | | |
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| | | | | | | | | | | |
| Please attach to this appli | cation copies o | of the cou | ırt orders or leg | al docume | nts creating this | s relationship. | | | | |
| Children insured elsev | where? 🔲 ` | Yes 📮 | No If "Ye | s", insur | ed by: | | _ Policy | Numbe | r: | |
| Are any of the other D | | | | | | | | | | |
| If yes, please complet | | | | oga. oa. | or guar | олол.юр от ол | | | | |
| Dependent | Perso | | | | elationship to De | ependent | Ad | ddress of C | Custodian | |
| ., | | | | | | | | | | |
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| | | | | | | | | | | |
| f you are not the pare | • | | | es each | such child re | eside with you? | | | | |
| _ Yes ☐ No If "N | Io", which cl | hildren | do not? | | | | | | | |
| | | | | | | COVERAGE | | | | |
| f any person for whom ap any waiting period under t | | | | | | | | | | |
| be entitled to credit toward | ds any pre-exi | isting co | nditions restric | tion unde | r the Medical E | Senefits Mutual pla | n for any | coverage | time unde | er the pric |
| olan. In order to claim this | s credit, a cer | rtificate o | | | | | | | | |
| coverage, should be attac If coverage was lost u | | | lth nlan with | in 30 da | vs of the dat | e of this applic | ation lie | t reason | the cov | erane u |
| terminated under the | | iioi iiea | itii piaii witii | iii 30 ua | ys or the dar | e or triis applic | alion, lis | i icason | lile covi | erage v |
| | p | | | | | | | | | |
| | | ME | DICAL LUCT | ODV AND | CUDDENT | CONDITIONS | | | | |
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| Full Name | Date of Birth | Height/Weight | Male or Female | Full-Time Student? (Y/N | You and/or your spouse provide over 50% Support | Natural Child | Adopted Child | Step- Child | Custody or Guardian- ship* |
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