MedBen
Where peace of mind is your best benefit

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** ❑

EMPLOYEE APPLICATION – [LARGE GROUP ONLY (50+ COVERED MEDICAL LIVES)]

READ CAREFULLY AND COMPLETE IN INK TO PREVENT YOUR COVERAGE FROM BEING DELAYED.
COMPLETE ALL SECTIONS OF THE APPLICATION. SIGN AND DATE THE AGREEMENT AND AUTHORIZATION.
IF YOU WANT LIFE ONLY COVERAGE, YOU MUST COMPLETE THE ENTIRE APPLICATION. IF YOU ARE APPLYING FOR SPOUSAL COVERAGE, HAVE YOUR SPOUSE SIGN AND DATE THE AGREEMENT AND AUTHORIZATION.

❶

Employee Information (Please print in ink): Social Security Number

Name _____ (Last / First / Middle Initial)

Home Address _____ (Street / City / State / Zip) Telephone

Employee Date of Birth _____ Mo. Day Yr.	**Sex** ❑ Male ❑ Female	**Marital Status** ❑ Married ❑ Divorced ❑ Widowed ❑ Single ❑ Common Law*	**Who Is to Be Insured** ❑ **Life Only Coverage** ❑ Employee Only ❑ Employee and Spouse ❑ Employee and Children ❑ Employee, Spouse & Children	**Date Hired** _____ Mo. Day Yr.
Earnings $_____ ❑ Yearly ❑ Weekly ❑ Monthly	**Height** / **Weight**			**COBRA Election Date** ___/___/___ Mo. Day Yr

Employed by _____ (Company Name / City, State of Employment / Group/Account Number)

Occupation _____ Hours Worked Weekly _____

Beneficiary Name _____ (Last / First / MI) Relationship _____

** Complete Supplemental Information - Common Law Relationship*

❷

EMPLOYEE LIFE ONLY COVERAGE – WAIVER OF COVERAGE

All eligible employees must enroll for Life and AD&D, and if included in the employer's plan, Disability coverage.

If you are declining enrollment for yourself or your dependents (including your spouse) because you have other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, placement for adoption, or your appointment as a legal guardian, you may be able to enroll yourself and/or your dependents, provided that you request enrollment within 30 days after the date of the marriage or appointment of legal guardianship, or 31 days of a birth, adoption, or placement for adoption. This plan will also allow enrollments as necessary to comply with the terms of medical child support orders, or qualified medical child support orders, as defined in applicable state or federal law. Other than as described above, you may not be eligible to enroll in this plan if you waive coverage at this time or may be subject to an additional waiting period, beginning with the date of late enrollment.

If Waiving Coverage, Information Will Appear on the Following Page(s)

❸

COMPLETE FOR DEPENDENT COVERAGE, including SPOUSE

Dependent coverage is not available for AD&D or Disability Insurance.
If you do not wish to cover your eligible dependents, please complete the Waiver of Coverage section above.

Spouse Name	Date of Birth	Height/ Weight	S.S. Number	Male or Female

Spouse employed? ❑ Yes ❑ No If "Yes", employed by _____ Date of Marriage: _____

Spouse insured elsewhere? ❑ Yes ❑ No If "Yes", insured by _____ Policy Number: _____

Dependent Children: Relationship (Check one)

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*
				Y N					
				Y N					
				Y N					
				Y N					

**Please attach to this application copies of the court orders or legal documents creating this relationship.*

Children insured elsewhere? ❑ Yes ❑ No If "Yes", insured by: _____ Policy Number: _____

Are any of the other Dependents listed above in the legal custody or guardianship of another Person? ❑ Yes ❑ No
If yes, please complete the following:

Dependent	Person with Legal Custody	Relationship to Dependent	Address of Custodian

If you are not the parent of any child listed above, does each such child reside with you?
❑ Yes ❑ No If "No", which children do not? _____

NOTICE REGARDING PRIOR HEALTH COVERAGE

If any person for whom application for coverage has been made above was covered under other health coverage within 62 days (not including any waiting period under this plan or any other plan) of the date such person's coverage would become effective under this plan, he or she may be entitled to credit towards any pre-existing conditions restriction under the Medical Benefits Mutual plan for any coverage time under the prior plan. In order to claim this credit, a certificate of creditable coverage from the prior plan, or other evidence documenting the person's prior coverage, should be attached to this form.

If coverage was lost under the prior health plan within 30 days of the date of this application, list reason the coverage was terminated under the prior plan.

_____

4 **MEDICAL HISTORY AND CURRENT CONDITIONS**

[Within the past [5] [#] years (up to and including the present) have any of the persons to be covered been hospitalized, or advised to be hospitalized; had surgery or advised to have surgery; had any serious injury or illness where medical attention, advice or treatment was received (other than minor colds or flu); been prescribed or taken any prescription medication; been advised of any abnormal results from a physical exam, lab test or blood work; or are you currently pregnant? If so, please provide details below (use additional paper if necessary):]

If Medical Information Has Been Entered It Will Appear on the Previous Page(s)

LIST ALL PRESCRIPTIONS YOU ARE CURRENTLY TAKING HERE:

5 **Read this Agreement and Authorization Carefully**

I hereby request coverage and authorize that any requested contribution for the insurance to which I may be entitled be deducted from my earnings. I am employed by the employer shown and am working at least the number of hours per week required by my Employer and shown on the Employer Application. I further understand that any failure to comply with the Utilization Review or Second Surgicial Opinion procedures may result in a reduction of benefits. I authorize (1) any physician, hospital, or other health practitioner or facility, (2) any insurance company or health care plan, (3) any state or federal agency providing health care benefits, and (4) any employer to provide Medical Benefits Mutual Life Insurance Co. or its legal representative any information in their possession which is relevant to this application for insurance regarding myself or my listed Dependent(s). This information will be used to determine the eligiblity for coverage and/or benefits for myself and my listed Dependent(s) and will be utilized by employees and agents of Medical Benefits Mutual Life Insurance Co. with responsibility for (1) reviewing applications and determining eligiblity for coverage, (2) payment of claims, and (3) any other health care operations. I hereby authorize and release any provider of health care services, claim administrators, insurers, reinsurers, pharmacy benefit managers, and others who have a legitimate need for such information for the purpose of review, investigation, or evaluation of a claim, to supply each other with information about the health status of, and health care services provided to, me and my listed Dependent(s). I understand that information disclosed by MedBen to any individuals listed in the preceding paragraph pursuant to this authorization may be subject to redisclosure by such individuals, and will no longer be protected by this authorization. This authorization is effective on the date signed and shall remain in effect for the duration of coverage under this policy. (You or any individual authorized by law to act on your behalf have a right to receive a copy of this authorization.) A photographic copy of this authorization shall be as valid as the original. I understand that if I fail to provide this authorization, MedBen will be unable to process my application for coverage. I further understand that I have the right to revoke this authorization by submitting such revocation to the Chief Privacy Officer, Medical Benefits Mutual Life Insurance Co. at the address listed on this application. Such revocation will not be effective to the extent that action has been taken in reliance upon this authorization prior to MedBen's receipt of my revocation or to the extent that MedBen has the right to contest my coverage or a claim thereunder under applicable law. I hereby certify that I have personally answered all of the questions on this form and that my answers are true and complete to the best of my knowledge and belief. I have legal proof which I can furnish upon request of my relationship to any person listed as a Dependent above. I understand that any misstatements (including the misstatement of any medical information), or failure to report (including failure to report any medical information), may be used as a basis for recission or cancellation of the insurance for me and my Dependent(s), if any.

Employee Signature _____ Date _____

Spouse Signature (if applying for coverage)_____ Date _____

I understand that if, upon receipt, the signature is more than 60 days old, a new application will be requested.

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Name: _____ SSN: _____

Dependent Children Relationship (Check one)

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				Y N					
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