PO Box 3620
Akron, Ohio 44309-3620

ENROLLMENT APPLICATION (LARGE GROUP – MEDICAL QUESTIONNAIRE)

HOW TO ENROLL IN SUMMACARE:

Please use this page as a guide in completing your enrollment application. **If you have any questions, please call SummaCare Customer Service at 330-996-8700 or 800-996-8701.**

- PLEASE PRINT OR TYPE information which is requested.
- Complete ALL information that is requested by "Employee". Applications that are incomplete may cause a delay in processing.
- If adding an adult child between the ages of 19-28, additional information may be requested to determine eligibility.
- **MAKE SURE YOUR SPOUSE SIGNS THE APPLICATION (if applicable).**

IMPORTANT: PLEASE ALSO FILL OUT THE MEDICAL HISTORY QUIESTIONNAIRE IF YOU ARE ENROLLING IN HEALTHCARE COVERAGE AT THIS TIME.

WAIVER OF COVERAGE

COMPLETE THIS SECTION ONLY IF YOU ARE ELIGIBLE FOR GROUP COVERAGE AND CHOOSE NOT TO ENROLL FOR HEALTH COVERAGE. ALSO, INDICATE IF YOU ARE WAIVING LIFE INSURANCE COVERAGE THROUGH SUMMACARE.

NAME		**DATE OF BIRTH**	
SS#		**DATE OF HIRE**	
ADDRESS		**CITY, STATE, ZIP**	
PHONE NUMBER		**EFFECTIVE DATE**	
EMPLOYER (GROUP) NAME/NUMBER			

REASON COVERAGE IS BEING WAIVED	**If Waiving Coverage, Information Will Appear on the Following Page(s)**

I also wish to waive life insurance coverage through SummaCare:	☐ YES ☐ NO ☐ N/A
I have had an opportunity to enroll in SummaCare and hereby waive coverage available through this employer group.	
Employee Signature	Date

SUMMACARE

SUMMACARE ENROLLMENT APPLICATION
LARGE GROUP – MEDICAL QUESTIONNAIRE

BENEFITS OFFICES SHOULD SEND COMPLETED FORM TO ELIGIBILITY:
MAIL: PO BOX 3620 Akron, OH 44309-3620 EMAIL: EnrollmentACTs@summacare.com
FAX: 330-996-8953

TO BE COMPLETED BY THE EMPLOYER - FAILURE TO COMPLETE ALL SECTIONS MAY DELAY ENROLLMENT

COVERAGE EFFECTIVE DATE	HIRE DATE	DATE RECEIVED BY EMPLOYER
GROUP NUMBER	DIVISION NUMBER	BENEFIT PLAN
EMPLOYEE CLASS ☐HOURLY ☐SALARY ☐OHIO LAW ☐COBRA ☐RETIREE ☐MEDICARE WRAP	TYPE OF PLAN ☐PPO_____(Underwritten by Summa Insurance Company) ☐QUALIFIED PLAN ☐HSA ☐HRA ☐OTHER_____	
QUALIFYING EVENT: ☐ NEW HIRE ☐REHIRE ☐OPEN ENROLLMENT (RENEWAL MONTH_____) ☐LOSS OF COVERAGE (PLEASE INCLUDE CERTIFICATE OF CREDITABLE COVERAGE WITH APPLICATION) ☐OTHER _____		

TO BE COMPLETED BY EMPLOYEE - RETURN TO YOUR BENEFITS OFFICE
DO NOT SEND DIRECTLY TO SUMMACARE

EMPLOYEE NAME			SOCIAL SECURITY NUMBER	
TYPE OF COVERAGE SELECTED (CHECK ONE): ☐SINGLE ☐EMPLOYEE & SPOUSE ONLY ☐EMPLOYEE & CHILDREN ONLY ☐FAMILY				
ADDRESS NUMBER & STREET	CITY	STATE	ZIP CODE	COUNTY
HOME PHONE #	WORK PHONE # EXT.	EMAIL ADDRESS		
MARITAL STATUS : ☐SINGLE ☐MARRIED ☐DIVORCED ☐LEGALLY SEPARATED ☐WIDOWED				
ALL INFORMATION BELOW REGARDING LANGUAGE AND RACE IS OPTIONAL				
PREFERRED SPOKEN LANGUAGE	PREFERRED WRITTEN LANGUAGE	RACE		

ONLY COMPLETE THE FOLLOWING INFORMATION FOR ALL PERSONS TO BE COVERED, INCLUDING YOURSELF. Using the SummaCare Provider Directory, please list the name of your Primary Provider for each person to be covered. If the address of any of the following individuals is different from the address above, please list the name and address on a separate sheet and attach them to this form.

SOCIAL SECURITY NUMBER (REQUIRED FOR ALL ENROLLING)	LAST NAME	FIRST NAME	MI	RELATIONSHIP TO EMPLOYEE	DATE OF BIRTH	SEX (M/F)

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

IF ADDING AN ADULT CHILD BETWEEN THE AGES OF 19-28, ADDITIONAL INFORMATION MAY BE REQUESTED TO DETERMINE ELIGIBILITY.

Employee Name: _____ SSN: _____

SOCIAL SECURITY NUMBER	LAST NAME	FIRST NAME	MI	RELATIONSHIP TO EMPLOYEE	DATE OF BIRTH	SEX (M/F)	Primary Physician Name
				Employee			

Dependent Address:

PROVIDER INFORMATION

Information is not required but will assist in managing your care. Please complete only for those individuals enrolling.

NAME	PRIMARY PHYSICIAN NAME	CODE	ARE YOU A NEW PATIENT (Y/N)

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

COORDINATION OF BENEFITS INFORMATION

Have you been covered under any other health plan within the last 12 months? ☐ No ☐ Yes

If yes, please provide a copy of the Certificate of Creditable Coverage from the prior carrier stating the coverage effective and end dates.

NOTICE - If this form is not received, enrollment and/or claims payment can be held up.

ARE YOU OR YOUR DEPENDENTS CURRENTLY COVERED BY OTHER HEALTH INSURANCE? ☐ NO ☐ YES

If "yes" please complete the following information:

INSURANCE COMPANY NAME & ADDRESS	POLICY HOLDER NAME / DATE OF BIRTH	EFFECTIVE DATE OF POLICY	NAMES OF COVERED FAMILY MEMBERS	GROUP #	COVERAGE TYPE

If Prior / Other Medical Coverage Has Been Entered It Will Appear on the Following Page(s)

☐ CHECK HERE IF YOUR SPOUSE IS CURRENTLY ELIGIBLE FOR HEALTH INSURANCE COVERAGE THROUGH HIS/HER EMPLOYER.

MEDICARE ELIGIBILITY

Complete this section if you or your dependents are covered by Medicare Part A and/or B.

NAME OF COVERED PERSON	MEDICARE #	CHECK WHICH PARTS	EFFECTIVE DATES FOR PART A/B

If Medicare Information Has Been Entered It Will Appear on the Following Page(s)

EMPLOYEE MUST SIGN AND DATE THE FOLLOWING CERTIFICATION AND AUTHORIZATION: By electing SummaCare, I understand that I and all my eligible dependents accept the SummaCare option in lieu of the benefits provided by my employer's other medical benefits plans. I certify that all information supplied on this form is true and complete to the best of my knowledge. I understand that all benefits for myself and my eligible dependents will be provided in accordance with the plan documents. I am familiar with and agree to abide by the terms and conditions governing membership and receipt of health services in the plan and agree to the provisions stated on the reverse side of this form, which I have read and understand.

EMPLOYEE SIGNATURE _____ DATE_____

SPOUSE (If applying for coverage) _____ DATE_____

SPOUSE MUST SIGN APPLICATION IF APPLYING FOR COVERAGE OR APPLICATION WILL NOT BE ACCEPTED

SHORT-FORM MEDICAL HISTORY QUESTIONNAIRE

EMPLOYEE NAME: _____ SOCIAL SECURITY NUMBER: _____

1. **COMPLETE THE FOLLOWING INFORMATION FOR ALL PERSONS (APPLICANTS) APPLYING FOR COVERAGE.** For purposes of the following medical questions, the term "medical or social practitioner" includes but is not limited to: a doctor, nurse, psychologist, social worker, chiropractor, podiatrist, optometrist, osteopath, Christian Science practitioner, or a person affiliated with a self-help program such as Alcoholics Anonymous, a substance abuse program or weight loss program.

2. Have you or any of your listed dependents been diagnosed or treated in the past five years by a medical or social practitioner for any of the following conditions? (see below) ☐ Yes ☐ No

If "yes", please check condition(s) that apply and explain in the chart below:

	Condition	Y		Condition	Y		Condition	Y
1.	Immune Disorder (AIDS/HIV/Lupus)	☐	7.	Currently Pregnant? If yes, due date?	☐	13.	Rheumatoid Arthritis	☐
						14.	Multiple Sclerosis	☐
2.	Cancer/Tumor/Cyst	☐	8.	Bone/Muscle Disorder	☐	15.	COPD/Asthma	☐
3.	Heart/Circulatory Disorder	☐	9.	Back/Disc Disorder	☐	16.	Stroke	☐
4.	Diabetes/Endocrine	☐	10.	Blood Disorders	☐	17.	Crohn's	☐
5.	Mental/Nervous Disorder	☐	11.	Kidney/Liver Disease	☐	18.	Smoker	☐
6.	Alcohol/Drug Abuse	☐	12.	Transplant	☐	19.	Other	☐

3. Has future surgery, diagnostic testing or medical treatment been recommended for anyone applying for coverage, excluding AIDS or HIV?
☐ Yes ☐ No **If "yes", please explain in chart below.**

4. Has anyone applying for coverage been prescribed medication within the last 12 months? ☐ Yes ☐ No
If "yes", please list the mediations and dosages in chart below.

#	Patient's Name	Condition, Diagnosis & Type of Treatment	Medications & Dosages	Date(s) of Treatment(s)	Hospitalized? (Y/N)	Recovered? (Y/N)

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

WARNING: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE OR SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.