

SuperMed One

Application Instructions For Medical Mutual of Ohio

1. Print all pages of the application including instructions.
2. Complete all questions and sections of the application.
3. Complete the fax cover letter on the next page and fax to SuperMed One for review along with the completed application. If you do not have access to a fax machine, send the completed application to SuperMed One.

HELPFUL TIPS:

Here is a checklist of a few things that are commonly overlooked and are mandatory in processing your application.

- Indicate your requested effective date.
- Select your preferred billing method.
- Sign and date the application.

IMPORTANT:

If you have requested that your monthly premium be deducted automatically from your checking account, you must attach a voided check to the area provided and also complete, sign, and date the authorization form.

Mail completed application and check to:

SuperMed One
Attn: New Enrollment
P.O. Box 239
Litchfield, OH 44253

SuperMed One will review your application for completeness and accuracy before we submit it to Medical Mutual of Ohio for processing. This may reduce the approval time because they cannot process unclear or incomplete applications until the missing information has been gathered.

Please contact us if you have any questions regarding the application or the application process. You may reach us at 800/722-7331 or e-mail us at sm1@insureonebenefits.com.

SuperMed One

FAX COVER LETTER

(Please ignore this form if you do not have access to a fax machine.)

****Please FAX this cover letter with the completed application to:**

SuperMed One

FAX# 330/721-8815

Dear SuperMed One,

Please accept my completed application for submittal and contact me to confirm receipt of this application

Name _____

E-mail _____

Date _____

Time _____

Please contact me at this phone number

_____ after you have reviewed my application for completeness and accuracy.

I will contact SuperMed One at 800/722-7331 to verify receipt of my application.

****I understand that SuperMed One will not review this application until the following business day if I faxed this application after 5:00PM or on a weekend**



| |
|---------------------------------|
| MMO USE ONLY |
| EFFECTIVE DATE: ___ / ___ / ___ |
| GROUP NUMBER: _____ |

SHORT TERM APPLICATION/CHANGE FORM — OHIO

INSTRUCTIONS: All questions must be answered. Incomplete applications will be returned.

Section I: Contract Holder Information

| | | | | | | |
|---|-------|----------|--------------------|--|------------------------|-------------------|
| Last Name | | MI | First Name | | Social Security Number | |
| Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed | | | | | Marriage Date: / / | Divorce Date: / / |
| Permanent Residence | | | City | | E-mail Address | |
| County | State | Zip Code | Best Contact # () | | Alternate # () | |
| Reason for Application: <input type="checkbox"/> Applying for new coverage <input type="checkbox"/> Applying for dependent-only coverage <input type="checkbox"/> Applying for change to current coverage | | | | | | |

LIST BELOW ALL INDIVIDUALS TO BE COVERED

| | First Name, MI (and last name, if different) | Social Security Number | Birth Date | Sex | Height | Weight | Tobacco User | Student |
|--------|---|---------------------------|------------|-----|--------|--------|---|---|
| Self | | | | | | | <input type="checkbox"/> Y <input type="checkbox"/> N | |
| Spouse | | | | | | | <input type="checkbox"/> Y <input type="checkbox"/> N | |
| 1 | | | | | | | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 2 | | | | | | | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 3 | | | | | | | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |

Section II: Federal and Ohio Open Enrollment Eligibility

1. Yes No Are you a **Federally Eligible Individual** or applying for coverage under the **Ohio Open Enrollment** requirements?

If Yes, **STOP HERE.** SuperMed One® is NOT a Federally Eligible or Ohio Open Enrollment product. For an information and application packet, please call Medical Mutual at 800/242-1936. SuperMed One may affect your status as a federally eligible individual. Visit the ohioinsurance.gov web site for more information.

Section III: Coverage Options

Requested Effective date: ___ / ___ / ___

SuperMed One Short Term:
Deductible Single/Family

- \$250/\$500 \$500/\$1,000
 \$1,000/\$2,000 \$1,500/\$3,000

Section IV: OTHER COVERAGE INFORMATION

Yes No Does **ANY PERSON TO BE COVERED** have any other type of health insurance (Accident, Medicare, Medicaid, etc.) or is **ANY PERSON TO BE COVERED** currently applying for any other health insurance? If yes, please complete the following:

| NAME | TYPE | NAME OF INSURANCE COMPANY |
|------|------|---------------------------|
| | | |
| | | |
| | | |
| | | |
| | | |

WARNING: Any person who, with intent to defraud or knowing that he is facilitating fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. (Ohio Revised Code Section 3999.21).

Section V: MEDICAL ELIGIBILITY QUESTIONS

1. Are YOU, YOUR SPOUSE or any DEPENDENT currently pregnant, an expectant parent, or in the process of adoption (even if not named on this application)? **YES** **NO**
2. Is ANY PERSON TO BE COVERED currently hospitalized or in a nursing home? **YES** **NO**
3. Has any insurance company refused coverage to ANY PERSON TO BE COVERED? **YES** **NO**
If yes, please explain _____
4. Within the last 12 months have YOU or ANY PERSON TO BE COVERED taken any prescription medications? **YES** **NO**
If yes, please list all medications* _____
5. Within the last five years, have YOU or ANY PERSON TO BE COVERED received any medical or surgical consultation, advice, or treatment for any chronic illness including: heart or circulatory system disorders; neurological disorders; respiratory disorders; immune system disorders, including Acquired Immune Deficiency Syndrome (AIDS); cancer or tumor; diabetes; alcoholism or alcohol abuse; drug abuse or chemical dependency? **YES** **NO**
If yes, please provide details (include dates of treatment)* _____

*If more space is required please attach additional sheets.

Section VI: BILLING INFORMATION

- CHOOSE ONE:**
- HOME** – Receive monthly premium billings
 - FINANCIAL INSTITUTION** – Have monthly automatic premium withdrawals
 - CREDIT CARD** – Have monthly premium billed to credit card
 - DIFFERENT BILLING ADDRESS** – Have home billing sent to a different address

If you wish to be billed through your financial institution, please complete the following authorization:

I authorize Medical Mutual of Ohio to initiate premium deductions from my account. The authorization will remain in effect until Medical Mutual of Ohio and my financial institution have received written notification from me within a reasonable time period to allow termination of the deduction.

Premiums are to be deducted from: Checking Savings (Please note: Not all financial institutions allow deductions from a savings account. Please verify this information with your financial institution.) (Deducted on the first business day of the month)

| | | | | |
|---|-------|-----|------------------------|--|
| Name and branch of bank/financial institution | | | Account Number | |
| Address | | | Account Holder's Name | |
| City | State | Zip | Transit Routing Number | |
| Account Holder's Signature | | | Date | |

Please attach a voided check for checking account or a deposit slip for savings account for verification of bank information.

If you wish to be billed through your credit card, please complete the following authorization:

- Mastercard Visa (Deducted on 2nd business day of the month)

| | | | |
|----------------------------|--|-----------------|--|
| Cardholder Name | | Card Number | |
| Bank Name (if applicable) | | Expiration Date | |
| Account Holder's Signature | | Date | |

If your permanent address is different than your billing address, complete the following:

| | | | | |
|-----------------|--|------------|-----|----|
| Last Name (C/O) | | First Name | | MI |
| Address | | | | |
| City | | State | Zip | |

Section VII: HOW DID YOU HEAR ABOUT SUPERMED ONE? (CHECK ONE)

- 1. Friend/family member
- 2. Yellow Pages
- 3. Insurance Agent
- 4. Advertisement in newspaper, magazine, etc.
- 5. Newspaper article
- 6. Internet/Web site
- 7. Radio
- 8. Mail
- 9. Through current employer
- 10. Other _____

ATTACH VOIDED CHECK OR DEPOSIT SLIP HERE

Section VIII: TERMS AND CONDITIONS

I hereby apply under Medical Mutual of Ohio's Group Trust for the coverage indicated on this application. I further agree to participate in such trust and agree to be bound to the relevant terms of the Master Group Contract(s) and the Trust Agreement.

1. I authorize release of information, without limitation, from any medical/medically related facility, prior health insurance carrier, the Medical Information Bureau Inc. (MIB), government agency or person to Medical Mutual of Ohio (MMO) and/or any affiliates or division of MMO: (a) to evaluate this application; (b) to adjudicate claims submitted on behalf of me or my dependents; (c) for utilization review programs to monitor health services or quality improvement activities and/or; (d) for credentialing purposes. I authorize MMO to provide a photocopy of this release to any physician or medical institution to obtain records for the purposes stated above. This authorization will be valid for a period of two and one-half years for the purpose of collecting information regarding this Application.
2. I agree that a medical examination of me may be required in connection with this Health Insurance Application. I further agree that I, as the Applicant, will be responsible to pay for the medical examination and/or the release of any and all records on behalf of myself, my spouse, and/or the listed dependents.
3. By signing below, I represent and warrant as follows: (a) I have thoroughly read and understand this Health Application and the questions asked herein; (b) I have answered each and every question set forth in this Application; (c) all of my answers to each of the questions are accurate, complete and true and (d) I did not sign a blank or partially completed Application. I agree that MMO, in its sole discretion, may rescind my policy at any time on the basis of any untrue, inaccurate or incomplete answer to any question in this Application, or any misrepresentation, omission or concealment on this Application, whether intentional or otherwise. I further agree that if a policy is issued, it will be issued by MMO in full reliance and in consideration of the information, answers and statements contained herein. I understand that this policy will be medically underwritten.
4. I have read the sales materials and understand the plan benefits, exclusions, and limitations as outlined therein. I acknowledge that the managed care features of this health insurance policy (such as the preferred provider organization network) have been explained to my satisfaction. I also understand that I may review a copy of the Master Group Contract(s) and Trust Agreement upon making such a written request to MMO.
5. No issuance, waiver, modification or change of policy or any of MMO rules or amendments shall be binding upon MMO unless it is in writing and signed by an authorized officer of MMO, as applicable.
6. Notice: Certain Pre-Existing Condition limitations will apply.
7. I represent that neither I nor my spouse are receiving any form of reimbursement or compensation for this coverage from any employer.
8. I understand that information submitted with this application may require further medical underwriting. If that underwriting discloses additional medical risk I understand that there may be a significant change in the rate charged for this coverage, or in certain cases the coverage may be rescinded. A permanent ID card will be issued following the final review and acceptance of the application.
9. I understand and agree that I am solely and exclusively responsible for the truth, accuracy and completeness of all of the answers contained in this application. I understand and agree that no agent or broker who may be assisting in the completion of this application has any authority (a) to waive any answer or any portion of any answer to any question on this application or any information MMO requests, (b) to advise me that I am not obligated to disclose any condition of which I am aware concerning my health or the health of any dependent included on the application, (c) to make any representation concerning health benefits that are inconsistent with, or different from, any written information provided by MMO or (d) to bind MMO in any way by making any statement, promise or representation that is not set out in writing in this application or regarding eligibility, benefits or issuance of a policy, (e) to answer any questions in, or insert any information on, this Application on my behalf, or (f) to approve coverage.
10. I understand and agree that I am responsible for disclosing all information required by this application, including but not limited to all health conditions and diagnoses of which I am aware. I understand and agree that MMO has the exclusive right to determine whether a particular condition or diagnosis is significant, that I do not have the right to evaluate whether a condition or diagnosis should or should not be disclosed on this application and that I am obligated to disclose even those conditions or diagnoses that I do not believe are significant or important.
11. My dependents and I understand and agree that any information obtained will not be released by the Company to any person or organization except to reinsuring companies, the MIB, or other persons or organizations performing healthcare operations or business or legal services in connection with any application, claim, or as may be otherwise lawfully required, or as we may further authorize. If a Consumer Reporting Agency is used, I (we) may request to be interviewed in connection with the preparation of the report. Once personal and health (including medical, dental, and pharmacy) information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal and state privacy requirements. A copy of this authorization request is available to me or my legal representative upon written request. A photographic copy of this authorization shall be as valid as the original. This authorization shall be valid for a period of two and one-half years. I have the right to revoke this authorization at any time. To revoke this authorization, I must do so in writing and send my written revocation to MMO's Privacy Office. The revocation will not apply to information that has already been released in response to this authorization. The revocation may adversely affect my application, a claim or a pending insurance action. The revocation will become effective after it is received by MMO's Privacy Office.
12. I understand and agree that no agent or broker has the authority (1) to bind Medical Mutual by making promises regarding eligibility, benefits or issuance of a policy; (2) to waive any answer or any portion of any answer to any question on this application or any information Medical Mutual requests; (3) approve coverage; (4) make or alter any contract on behalf of Medical Mutual or (5) waive or alter any of Medical Mutual's other rights or requirements. All contract terms must be in writing and signed or accepted in writing by an authorized representative of Medical Mutual to be binding on Medical Mutual.

I am signing this Health Application on my own behalf and on behalf of all listed dependents. An unaltered copy of this authorization is as valid as the original. I understand that I should not cancel any current health insurance coverage until I receive an approval letter and insurance policy from MMO.

| | | |
|---|------|---|
| Contract Holder's or Guardian's Signature | Date | Guardian's Social Security Number (if child-only policy) |
| Spouse's Signature | Date | Dependent's Signature if 18 or older Date |
| Dependent's Signature if 18 or older | Date | Dependent's Signature if 18 or older Date |

FOR OFFICE USE ONLY

| | |
|-------------------------|----------------------|
| Agent of Record | Tax I.D. |
| Royal Advantage® Broker | Commission Indicator |