MEDICAL MUTUAL®
doing business as Medical Health Insuring Corporation of Ohio

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CONSUMERS LIFE®
A MEDICAL MUTUAL COMPANY

Health and Life Application/Change Form — Ohio
For Individuals

OPEN ENROLLMENT

The 2017 Open Enrollment begins on November 1, 2016, and will last through January 31, 2017. The earliest effective date for the 2017 Open Enrollment will be January 1, 2017. Applications received before or on the 15th of the month will be effective the first day of the following month. Applications received after the 15th of the month will be effective the first day of the month plus one additional month. For example, if your application is received on or before December 15th, the effective date will be January 1st (the earliest effective date for the 2017 Open Enrollment); if your application is received on December 20th, the effective date will be February 1st.

The first month Premium must be received prior to the effective date of coverage in order to consider the application complete and in order to effectuate coverage.

Applications must be received during the Open Enrollment period. **See Billing Section for Payment Guidelines.**

SPECIAL ENROLLMENT

A Special Enrollment may be applicable for applicants who have a qualifying event as defined in the Special Enrollment section of the application, see Section I. Special Enrollment must take place within 60 days of the qualifying event. If there is no Special Enrollment, please skip to Section II of the application.

The effective date for the qualifying events are as follows:

- Effective on the date of the event when becoming a dependent through birth, adoption or placement for adoption.
- Effective the first day of the month following the receipt of the application and premium when the applicant has Loss of Minimum Essential Coverage (Loss of Minimum Essential Coverage does not include termination due to non-payment of premium, including COBRA premium, or in the event of rescission) or becomes a dependent through marriage.
- Effective the first day of the following month when the application is received on or before the 15th of the month for All other Qualifying Events noted in Section I of the application; if the application is received after the 15th of the month, the effective date for the applicant will be the first day of the month plus one additional month (see the Open Enrollment examples above).

In the event that a qualifying event occurs, Special Enrollment will be allowed within 60 days of the qualifying event. If the applicant is not applying due to a qualifying event, please skip to Section II of the application.

The first month Premium must be received prior to the effective date of coverage in order to consider the application complete and in order to effectuate coverage.

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MEDICAL MUTUAL USE ONLY
EFFECTIVE DATE: ____ / ____ / ____
GROUP NUMBER: _____

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

Section I: SPECIAL ENROLLMENT: In the event that a qualifying event occurs, Special Enrollment will be allowed within 60 days of the qualifying event. If the applicant is not applying due to a qualifying event, please skip to Section II of the application.

Check the box for the qualifying event that applies.

- ☐ I lost my job or hours were reduced.
- ☐ My employer stopped offering group health insurance coverage.
- ☐ My COBRA benefits expired.
- ☐ I no longer qualify for Medicaid or the Children's Health Insurance Program (CHIP).
- ☐ I got divorced or legally separated.
- ☐ Because of my age, I can no longer be covered on my parent's health insurance plan.
- ☐ My spouse or parent passed away.
- ☐ I had a baby.
- ☐ I adopted a child or obtained legal guardianship of a child.
- ☐ I am required by court order to provide health insurance for a dependent.
- ☐ I got married.
- ☐ I moved to Ohio.
- ☐ I moved within the state of Ohio. Please Note: Not all moves qualify for a special enrollment period.
- ☐ I lost my premium subsidy from the federal government.
- ☐ My current individual health insurance was renewed or cancelled by my health insurance company. (Date of qualifying event is the date of the renewal or cancellation.)

Date of qualifying event: _____

Section II: APPLICANT INFORMATION

Last Name	MI	First Name	
Permanent Residence		City	E-mail Address
County	State	Zip Code	Best Contact # ( )	Alternate # ( )

Reason for Application:
☐ Applying for change to current coverage
☐ Applying for new coverage
☐ Adding dependent
☐ Applying for Child-only coverage

WARNING: Any person who, with the 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.

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	First Name, MI (and last name, if different)	Social Security Number	Birth Date	Gender	Primary Care Physician (HMO Only)	Tobacco User[2]
Self						Y N
Spouse						Y N
Domestic Partner[1]						Y N
1						Y N
2						Y N
3						Y N
4						Y N
5						Y N
6						Y N
7						Y N
8						Y N

[1]Refer to Section IX, Number 13, Terms and Conditions, for domestic partner eligibility requirements.
[2]Tobacco Smoker definition – the legal use (other than religious or ceremonial) of any tobacco product on average four or more times per week within no longer than the last six months.

Section III: PRODUCTS[2]

Silver Plan Options – POS Options:
- ☐ MedMutual 1750 (1,750/3,500)
- ☐ MedMutual 2500 (2,500/5,000)
- ☐ MedMutual 3500 (3,500/7,000)
- ☐ MedMutual 4000 HSA (4,000/8,000)

Silver Plan Options – HMO Options:
- ☐ MedMutual HMO 1750 – Mercy (1,750/3,500)
- ☐ MedMutual HMO 1750 – ProMedica (1,750/3,500)
- ☐ MedMutual HMO 4000 HSA – Mercy (4,000/8,000)
- ☐ MedMutual HMO 4000 HSA – ProMedica (4,000/8,000)

Bronze Plan Options – POS Options:
- ☐ MedMutual 5000 (5,000/10,000)
- ☐ MedMutual 6400 HSA (6,400/12,800)
- ☐ MedMutual 7150 HSA (7,150/14,300)

Bronze Plan Options – HMO Options:
- ☐ MedMutual HMO 6400 HSA – Mercy (6,400/12,800)
- ☐ MedMutual HMO 6400 HSA – ProMedica (6,400/12,800)
- ☐ MedMutual HMO 7150 – Mercy (7,150/14,300)
- ☐ MedMutual HMO 7150 – ProMedica (7,150/14,300)

Other
- ☐ Other (Product Name)_____

Ancillary Options[1]:
- ☐ MedMutual Dental 1 (Includes Pediatric Dental)
- ☐ MedMutual Dental 2 (Includes Pediatric Dental)
- ☐ MedMutual Dental 3 (Includes Pediatric Dental)
- ☐ MedMutual Pediatric Dental (not purchasing a medical plan)
- ☐ Waiving Pediatric Dental coverage[2]
- ☐ MedMutual Vision
- ☐ Life Coverage (must be purchased with Medical and Sections IV and V must be completed)

[1] Dental, Vision and Life coverage can be purchased as a stand-alone product. One year of premium is due when purchased as a stand-alone product.

[2] Medical plan designs include an Exchange certified Pediatric Dental plan unless Pediatric Dental is purchased elsewhere; if purchased elsewhere, proof of coverage for an Exchange certified Pediatric Dental plan must be supplied with the application to Medical Mutual. If proof is not received, Pediatric Dental and the corresponding rate will be included into the plan that was purchased. If a Medical Mutual Dental Rider is purchased, Pediatric Dental will be included.

Sections IV and V are required only if applying for Life Insurance

Section IV: LIFE PRODUCTS

Applicant Basic Life Insurance
☐ $10,000 ☐ $20,000 ☐ $30,000 ☐ $40,000 ☐ $50,000

Applicant Basic AD&D Insurance
☐ $10,000 ☐ $20,000 ☐ $30,000 ☐ $40,000 ☐ $50,000

Spouse Basic Life Insurance
☐ $10,000 ☐ $20,000 ☐ $30,000 ☐ $40,000 ☐ $50,000

Spouse Basic AD&D Insurance
☐ $10,000 ☐ $20,000 ☐ $30,000 ☐ $40,000 ☐ $50,000

Dependent Life Insurance
☐ $10,000

Do you, the applicant, own an existing life policy or annuity contract? ☐ Yes ☐ No
If you answered "YES" to the above questions, inform the agent who will provide you an "Important Notice: Appendix A, which you must read and complete.

By applying for this proposed life policy, do you intend to replace, discontinue or change any existing life policy or annuity contract?
☐ Yes ☐ No

It is understood and agreed that this application shall be made part of the policies for which application is made, and it is further understood:

(1) Basic Life and Dependent Life are subject to the approval of Consumers Life Insurance Company (CLIC), and nothing contained herein shall be binding upon Consumers Life until this application is approved and accepted at CLIC's home office.

No waiver or change will bind CLIC unless signed by an Executive Officer of CLIC.

Section IV: LIFE PRODUCTS (continued)

If the proposed insured answers "yes" to any of the following questions 1 through 8 in this section, that person is not eligible for life insurance coverage under this application. If the contract holder is not eligible, dependents will not be eligible either.

To the best of your knowledge and belief:

1. Has the proposed insured ever tested positive for exposure to the HIV infection, or been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) caused by the HIV infection or other sickness or condition derived from such infection? ☐ Yes ☐ No
2. Has the proposed insured **ever** (a) been diagnosed with, or (b) been advised by a member of the medical profession to seek treatment for, or (c) consulted with a health care provider regarding:
   - (a) Coronary Artery Disease, Heart Attack, Coronary Artery Bypass Surgery, Angioplasty, Stent Placement, Heart Murmur/Valvular Heart Disease or Replacement, Cardiomyopathy, Congenital Heart Disease, Stroke/mini-stroke, abnormal heart rhythm, or Cerebral or Symptomatic Aneurysm? ☐ Yes ☐ No
   - (b) Chronic Lung Disease (except mild Asthma), Chronic Bronchitis, Emphysema, Sarcoidosis or Cystic Fibrosis? ☐ Yes ☐ No
   - (c) Bipolar Depression, Schizophrenia, Alzheimer's Disease, Dementia, Parkinson's Disease, Demyelinating Disease including Multiple Sclerosis, Huntington's Disease, Hydrocephalus, or any other disease of the central nervous system? ☐ Yes ☐ No
   - (d) Chronic Kidney Disease, end-stage Renal Disease with dialysis, or Liver Disease including Cirrhosis, Hepatitis B or Hepatitis C? ☐ Yes ☐ No
   - (e) Diabetes except gestational or with vascular or renal complications? ☐ Yes ☐ No
   - (f) Cancer, Leukemia, Melanoma or any other internal cancer (except basal cell or squamous cell skin cancer)? ☐ Yes ☐ No
   - (g) Systemic Lupus or Scleroderma? ☐ Yes ☐ No
   - (h) an organ transplant? ☐ Yes ☐ No
3. **In the past 12 months**, has the proposed insured:
   - (a) required the assistance of another person or a device of any kind for bathing, dressing, eating, toileting, getting in and out of a chair or bed, or the management of bowel or bladder problems? ☐ Yes ☐ No
   - (b) received, or been advised by a licensed member of the medical profession to have, any of the following types of care: nursing home, assisted living facility, adult day care facility, home health care services, or physical, occupational, speech therapy, or is the proposed insured currently confined to any hospital or other medical facility? ☐ Yes ☐ No
   - (c) used any of the following: walker, wheelchair, electric scooter, oxygen or catheter? ☐ Yes ☐ No
   - (d) applied for, received, or is the proposed insured currently receiving disability, hospital, or medical benefits from any insurance company, government, employer, or other source other than for maternity? ☐ Yes ☐ No
4. **In the past 12 months**, has the proposed insured:
   - (a) been advised by a member of the medical profession to have a surgical operation, diagnostic testing (excluding HIV and AIDS) other than for routine screening purposes, treatment, or other procedure which has not been done? ☐ Yes ☐ No
   - (b) consulted a member of the medical profession for chronic cough, unexplained weight loss, fatigue or unexplained gastrointestinal bleeding? ☐ Yes ☐ No
5. **In the next 2 years**, will the proposed insured engage in any hazardous sports or activities such as motor sports racing, boat racing, parachuting/skydiving, hang gliding, base jumping, rock or mountain climbing? ☐ Yes ☐ No
6. **In the past 10 years**, has the proposed insured:
   - (a) used alcohol to a degree that required treatment or been advised to limit or discontinue its use by a physician, or other health care provider? ☐ Yes ☐ No
   - (b) used unlawful drugs in any form or used prescription drugs other than as prescribed by a physician (including sedatives, or tranquilizers) in any form? ☐ Yes ☐ No
   - (c) been convicted of or incarcerated for a felony? ☐ Yes ☐ No
   - (d) been hospitalized for high blood pressure or any mental or nervous disorder? ☐ Yes ☐ No
7. **In the past 10 years**, has the proposed insured been convicted of driving under the influence of drugs or alcohol, been convicted of reckless driving, or had four or more moving violations? ☐ Yes ☐ No
8. Does the proposed insured's weight fall outside of the acceptable weight range of the following height and weight chart? ☐ Yes ☐ No

Section IV: LIFE PRODUCTS (continued)

Height	Acceptable Weight Range	Height	Acceptable Weight Range
4' 5" but less than 4'6"	72 lbs to 154 lbs	5' 9" but less than 5'10"	125 lbs to 249 lbs
4' 6" but less than 4'7"	75 lbs to 156 lbs	5' 10" but less than 5'11"	129 lbs to 257 lbs
4' 7" but less than 4'8"	79 lbs to 159 lbs	5' 11" but less than 6'0"	132 lbs to 265 lbs
4' 8" but less than 4'9"	82 lbs to 161 lbs	6' 0" but less than 6'1"	136 lbs to 272 lbs
4' 9" but less than 4'10"	85 lbs to 167 lbs	6' 1" but less than 6'2"	140 lbs to 280 lbs
4' 10" but less than 4'11"	88 lbs to 173 lbs	6' 2" but less than 6'3"	144 lbs to 288 lbs
4' 11" but less than 5'0"	91 lbs to 180 lbs	6' 3" but less than 6'4"	148 lbs to 296 lbs
5' 0" but less than 5'1"	95 lbs to 186 lbs	6' 4" but less than 6'5"	152 lbs to 305 lbs
5' 1" but less than 5'2"	98 lbs to 193 lbs	6' 5" but less than 6'6"	156 lbs to 313 lbs
5' 2" but less than 5'3"	101 lbs to 199 lbs	6' 6" but less than 6'7"	160 lbs to 321 lbs
5' 3" but less than 5'4"	104 lbs to 206 lbs	6' 7" but less than 6'8"	164 lbs to 330 lbs
5' 4" but less than 5'5"	108 lbs to 213 lbs	6' 8" but less than 6'9"	168 lbs to 339 lbs
5' 5" but less than 5'6"	111 lbs to 220 lbs	6' 9" but less than 6'10"	172 lbs to 347 lbs
5' 6" but less than 5'7"	114 lbs to 227 lbs	6' 10" but less than 6'11"	177 lbs to 356 lbs
5' 7" but less than 5'8"	118 lbs to 235 lbs	6' 11" but less than 7'0"	181 lbs to 365 lbs
5' 8" but less than 5'9"	121 lbs to 242 lbs	7' 0" but less than 7'1"	184 lbs to 369 lbs

If any Medical Eligibility questions (Section IV 1-8) are checked "YES", please note below, who the condition applies to.

QUESTION NUMBER	PATIENT FIRST NAME	DATE OF BIRTH
EXAMPLE: 2a	*Mark*	/ /

Section V: APPLICANT BENEFICIARY DESIGNATION

If two or more primary beneficiaries are named, and you do not list benefit percentages, proceeds will be paid in equal shares to the named primary beneficiaries who survive you. If no primary beneficiary survives you, proceeds will be paid to the contingent beneficiary(ies). If you list benefit percentages, the total must equal 100%.

LAST NAME FIRST NAME	DATE OF BIRTH	RELATIONSHIP	BENEFIT %
Primary	/ /		%
Primary	/ /		%
Contingent	/ /		%
Contingent	/ /		%

Spouse Beneficiary Designation

If two or more primary beneficiaries are named, and you do not list benefit percentages, proceeds will be paid in equal shares to the named primary beneficiaries who survive you. If no primary beneficiary survives you, proceeds will be paid to the contingent beneficiary(ies). If you list benefit percentages, the total must equal 100%.

LAST NAME	FIRST NAME	DATE OF BIRTH	RELATIONSHIP	BENEFIT %
Primary		/ /		%
Primary		/ /		%
Contingent		/ /		%
Contingent		/ /		%

Section VI: OTHER COVERAGE INFORMATION

1. Any person to be covered currently enrolled in Medicare Part A or Part B? ☐ Yes ☐ No If yes, please complete the following:

NAME	INDICATE MEDICARE PARTS A AND OR B

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

NAME	TYPE	NAME OF INSURANCE COMPANY

3. Does **ANY PERSON TO BE COVERED** have a condition covered by Workers' Compensation? ☐ Yes ☐ No

NAME	WORKERS' COMPENSATION NUMBER	MEDICAL CONDITION

Section VII: US CITIZENSHIP

Are all applicants listed on this application US Citizens, nationals or lawfully present non-citizens?

☐ Yes ☐ No If No, please indicate which applicant/s _____

_____

_____

_____

_____

Section VIII: BILLING INFORMATION

The first month's premium payment with the receipt of the application is required; coverage will not be effectuated without a completed application and the first month's premium payment.

HOW DO YOU WANT TO MAKE YOUR FIRST PAYMENT?

1. ☐ **FINANCIAL INSTITUTION – Complete the Financial Institution Section below.**
2. ☐ **CREDIT CARD – Complete the Credit Card Section below.**
3. ☐ **CHECK** (In case of insufficient funds, a $20 returned item fee may be applied); **must be included with the application.**

☐ FINANCIAL INSTITUTION*

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

I authorize Medical Mutual of Ohio®/Consumers Life Insurance Company® to initiate premium payments from my account. The authorization will remain in effect until Medical Mutual of Ohio/Consumers Life Insurance Company and my financial institution have received written notification from me within a reasonable time period to allow termination of the payment arrangement.

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.)

In case of insufficient funds, a $20 returned item fee will be applied.

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

Please attach a voided check for checking account or a deposit slip for savings account in order for our office to verify the bank information.

ATTACH VOIDED CHECK OR DEPOSIT SLIP HERE

☐ CREDIT CARD*

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

☐ Mastercard ☐ Visa ☐ Discover

Cardholder Name	Card Number
	CSC – The 3 digit code on back of your credit card
Bank Name (if applicable)	Expiration Date
Account Holder's Signature	Date

*Please note, the information provided above will **NOT be** used to set up future automated payments. An invoice will be generated and mailed to you; your invoice will advise on options to make your future monthly payments.

Section IX: TERMS AND CONDITIONS

I hereby apply to the carrier(s) offering the coverage indicated on this application. Your insurance is being offered through Medical Mutual of Ohio and/or one of its wholly owned subsidiaries, Consumers Life Insurance Company or Medical Health Insuring Corporation of Ohio, collectively referred to as "Medical Mutual."

1. I authorize release of information, without limitation, from any medical/medically related facility, prior health insurance carrier, prescription history database supplier, pharmacy benefit manager, government agency or person to Medical Mutual and/or any affiliates or division of Medical Mutual: (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 Medical Mutual 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 understand that the life insurance benefits for which I am applying are subject to medical eligibility questions and I agree that I, as the Applicant, have answered the medical eligibility questions to the best of my knowledge and belief on behalf of my spouse, and/or dependents. I also understand that if I answered "yes" to any of the medical eligibility questions that I, my spouse and/or dependents are NOT eligible for the life insurance benefits.
3. By signing below, I represent and warrant as follows: (a) I have thoroughly read and understand this Health and Life 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 Medical Mutual, in their sole discretion, may rescind my policy on the basis of any material misrepresentation or fraudulent response to any question in this Application. I further agree that if a policy is issued, it will be issued by Medical Mutual in full reliance and in consideration of the information, answers and statements contained herein.
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, if applicable, upon making such a written request to Medical Mutual.
5. No issuance, waiver, modification or change of policy or any of Medical Mutual rules or amendments shall be binding upon Medical Mutual unless it is in writing and signed by an authorized officer of Medical Mutual, as applicable.
6. I represent that neither I nor my spouse are receiving any form of payment, reimbursement or compensation for this coverage from any employer.
7. An ID card and certificate book, which explains my benefits, will be issued following the final review and acceptance of this application. I understand my certificate book, changes to my certificate book, Summary of Benefits (SBCs), pharmacy benefits notifications [including, but not limited to, notifications for changes to formulary, coverage management (prior authorization, step therapy, quantity limits), specialty drugs, compound drugs, pharmacy networks, copays or covered drugs], Notice of Privacy Practices, health related communications, legal notices and other health plan documents will be made available to me electronically through My Health Plan, Medical Mutual's secure member website. I will receive an email from Medical Mutual with instructions on how to create a My Health Plan account. I also understand I may request a free paper copy of my documents, change my paperless preference for free or update my contact information at any time through My Health Plan or by calling Customer Care at the phone number on my ID card.
8. 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 Medical Mutual 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 Medical Mutual or (d) to bind Medical Mutual 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.
9. 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 Medical Mutual 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.

Section IX: TERMS AND CONDITIONS (continued)

10. 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, or other persons or organizations performing health care operations, business or legal services, or obtaining payment for premiums in connection with any application, claim, or as may be otherwise permitted by our Notice of Privacy Practices, 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 Medical Mutual'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 Medical Mutual's Privacy Office.
11. I understand and acknowledge that this authorization extends to all medical records, including records which may contain information regarding treatment for physical and mental illness, alcohol/drug abuse and/or HIV – AIDS test results or diagnosis. I expressly consent to the release of such information.
12. I understand that I have the right to cancel this coverage within 10 days of receipt of my certificate booklet/policy with a full refund of any premium paid.
13. If I am applying for coverage for my domestic partner, I represent and warrant that I and my domestic partner: 1) cohabit and reside together in the same residence and have done so for at least six months and intend to do so indefinitely; 2) are engaged in an exclusive and committed relationship and are financially interdependent; 3) are both at least 18 years of age and are each other's sole domestic partner; 4) are not married or separated from anyone else; 5) have not had another domestic partner within six months of establishing the current domestic partnership; 6) are not related by blood; and 7) are not in this relationship solely for the purpose of obtaining insurance benefits.
14. I understand that I must be a resident of, and live in, the State of Ohio at least six (6) months of each year, to be eligible for this policy.

I am signing this 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 or life insurance coverage until I receive an approval letter and certificate booklet/policy from Medical Mutual.

Applicant'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

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).

If you are working with a Broker/Agent, please complete with your Broker/Agent information.

Sold — Account Executive and Code	
Service — Account Executive and Code	

or

Agent of Record Stacia A Cox -- Ohio Dental Association	Tax I.D. 236114980 311200910
Royal Advantage® Broker Cornerstone	Commission Indicator

Multi-Language Interpreter Services & Nondiscrimination Notice

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ATTENTION: If you speak <insert language>, language assistance services, free of charge, are available to you. Call 1-800-382-5729 (TTY: 711).

Spanish

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-382-5729 (TTY: 711).

Chinese

注意:如果您使用繁體中文,您可以免費獲得語言援助服務。請致電 1-800-382-5729 (TTY: 711)。

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-382-5729 (TTY: 711).

Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-283-008-9275 رقم هاتف الصم والبكم: 117).

Pennsylvania Dutch

Wann du Deitsch schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-382-5729 (TTY: 711).

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-382-5729 (телетайп: 711).

French

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-382-5729 (ATS: 711).

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-382-5729 (TTY: 711).

Oromo

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-382-5729 (TTY: 711).

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-382-5729 (TTY: 711)번으로 전화해 주십시오.

Italian

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-382-5729 (TTY: 711).

Japanese

注意事項:日本語を話される場合、無料の言語支援をご利用いただけます。1-800-382-5729 (TTY: 711) まで、お電話にてご連絡ください。

Dutch

AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-800-382-5729 (TTY: 711).

Ukrainian

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-382-5729 (телетайп: 711).

Romanian

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-382-5729 (TTY: 711).

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Paul Mancino, Vice President, Assistant General Counsel & Deputy Compliance Officer
Medical Mutual of Ohio
2060 East Ninth Street
Cleveland, OH 44115-1355

Phone: (216) 687-2675
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- By mail at:
  U.S. Department of Health and Human Services
  200 Independence Avenue, SW Room 509F
  HHH Building
  Washington, DC 20201-0004
- By phone at:
  (800) 368-1019 (TDD: (800) 537-7697)
- Complaint forms are available at:
  hhs.gov/ocr/office/file/index.html

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