



# APPLICATION AND POLICY CHANGE

|                          |         |
|--------------------------|---------|
| GROUP #<br><b>911457</b> | SECTION |
|--------------------------|---------|

## 1. (Please Print) ABOUT YOU AND YOUR JOB...

|                         |  |                             |                              |   |                               |
|-------------------------|--|-----------------------------|------------------------------|---|-------------------------------|
| YOUR LAST NAME          |  | YOUR SOCIAL SECURITY NUMBER |                              | COMPANY NAME / EMPLOYER<br><b>Perry Hocking ESC</b> |                               |
| YOUR FIRST NAME         | M.I.   | YOUR DATE OF BIRTH<br>/ /   | SEX (M or F)                 |   |                               |
| YOUR STREET ADDRESS     |  |                             | BUSINESS PHONE<br>[ ] - EXT. |   |                               |
| CITY                    |  | STATE                       | ZIP CODE                     |   | FULL TIME DATE OF HIRE<br>/ / |
| HOME PHONE NO.<br>[ ] - | MARITAL STATUS: <input type="checkbox"/> Single <input type="checkbox"/> Married<br><input type="checkbox"/> Divorced <input type="checkbox"/> Widowed |                             | DATE MARRIED<br>/ /          |   |                               |

## 2. (Please Print) WHAT DO YOU WANT DONE...

|  |                                |
|--|--------------------------------|
| WHO DO YOU WANT COVERED?<br><input type="checkbox"/> Single Policy<br><input type="checkbox"/> Family Policy | POLICY (CHANGE) EFFECTIVE DATE |
|--|--------------------------------|

## 3. (Please Print) ABOUT YOU AND YOUR DEPENDENTS...

|        | (A)DD<br>(C)HANGE<br>(D)ELETE | FIRST NAME | LAST NAME (IF DIFFERENT) | SOCIAL SECURITY # | DATE OF BIRTH | SEX<br>(M or F) | (C)HILD<br>(S)TEPCHILD<br>(O)THER |
|--------|-------------------------------|------------|--------------------------|-------------------|---------------|-----------------|-----------------------------------|
| Spouse |                               |            |                          | -- --             | / /           |                 |                                   |
| 1      |                               |            |                          | -- --             | / /           |                 |                                   |
| 2      |                               |            |                          | -- --             | / /           |                 |                                   |
| 3      |                               |            |                          | -- --             | / /           |                 |                                   |
| 4      |                               |            |                          | -- --             | / /           |                 |                                   |

## 4. (Please Print) ABOUT YOUR OTHER HEALTH INSURANCE AND MEDICARE...

DO YOU OR ANY OF YOUR DEPENDENTS HAVE ANY OTHER HEALTH COVERAGE?  YES  NO (If "Yes," complete the section below.)

| NAME OF POLICYHOLDER | NAME & ADDRESS OF OTHER INSURANCE COMPANY | POLICY NUMBER | EFFECTIVE DATE |
|----------------------|---|---------------|----------------|
|                      |   |               | / /            |
|                      |   |               | / /            |
|                      |   |               | / /            |
|                      |   |               | / /            |

**MEDICARE INFORMATION:**  
 Are you covered by Medicare?  YES  NO If "Yes," Medicare #: \_\_\_\_\_  
 Is your spouse or dependent covered by Medicare?  YES  NO If "Yes," Medicare #: \_\_\_\_\_

|  |             |                                       |
|--|-------------|---------------------------------------|
| EFFECTIVE MEDICARE DATE: You<br>PART A: / /                | PART B: / / | <input type="checkbox"/> Hemodialysis |
| EFFECTIVE MEDICARE DATE: Spouse / Dependent<br>PART A: / / | PART B: / / | <input type="checkbox"/> Hemodialysis |

## 5. SIGNATURES - Sign after completing and reading all applicable sections (including other side of this application).

I have read all of the statements contained in this application, and declare by signing this application that I am an active, eligible, compensated, full-time employee and that the information I have provided is true and complete to the best of my knowledge.

\_\_\_\_\_  
Your Signature

\_\_\_\_\_  
Date

## WAIVER

If you do not want any coverage OR if you reject some of the coverage options but accept others, complete this waiver...

### CHECK ONE BOX IN SECTION A AND COMPLETE SECTIONS B AND C

**A. WAIVED COVERAGES:** I do NOT want...(Check one)

- HEALTH through MMO  
 Health through MMO for the following dependents only: (Remember to complete the rest of this application)

1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_ 4) \_\_\_\_\_ 5) \_\_\_\_\_

**B. CURRENT HEALTH COVERAGE STATUS:** I have...(Check one)

- Coverage through my Current Employer: \_\_\_\_\_  
Other Insurance Company Name
- Coverage through my Spouse's Employer: \_\_\_\_\_  
Spouse's Company Name                      Spouse's Name                      Spouse's Social Security #
- Other coverage through MMO       No coverage       Other coverage: \_\_\_\_\_

**C. AUTHORIZATION:** The terms of this waiver are explained in Section 6 of this application. I have read and understand those terms.

Current Employer/Company Name: \_\_\_\_\_

Print Employee Name: \_\_\_\_\_ Employee Social Security #: \_\_\_\_\_

Print Spouse Name: \_\_\_\_\_ Spouse Social Security #: \_\_\_\_\_

Signature of Employee: \_\_\_\_\_ Date: \_\_\_\_\_

## 6. THE EXPLANATION OF WAIVER

I understand that if I check any box in Question A of the Waiver of this application that I am choosing not to have those persons covered under the health insurance designated and any later application for enrollment and acceptance will be subject to all underwriting requirements.

If you are declining enrollment for yourself or your dependents (including your spouse) because of 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, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

## WARNINGS

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. (Ohio Revised Code Section 3999.21)

If you or your family members are covered by more than one health care plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and hospitals, and it may be impossible to comply with both plans at the same time. Before you enroll in this plan, read all of the rules very carefully and compare them with the rules of any other plan that covers you or your family.  
(Ohio Admin. Code Section 3901-1-56)