Youngstown STATE UNIVERSITY

Employee Application/Change Form

Group Number: 390078 Section #: _____

MM ID # _____

Effective date: _____

MEDICAL MUTUAL
CAROLINA CARE PLAN | CONSUMERS LIFE
*Super*Med Plus

A. EMPLOYEE INFORMATION

Last Name:	First Name:	Middle Initial:	Hire Date:	SS#:
Address:	City:	State:	Zip:	Employment Status: Active ☐ Retired ☐ COBRA ☐
Home Phone: ( )	Work Phone: ( )	Male ☐ Female ☐	Married ☐ Unmarried ☐	

B. COVERAGE INFORMATION

☐ New Enrollment — Reason : ☐ New Employee ☐ Rehired ☐ Open Enrollment ☐ Employment Eligibility Change Explain _____

☐ Change in Enrollment — Reason: ☐ Marriage: Date_____ ☐ Birth/Adoption: Date _____ ☐ Divorce/Death: Date _____ ☐ Open Enrollment
☐ Dependent Change: Date _____ ☐ Loss of coverage: Date _____ ☐ Other _____

Coverage Election ☐ **Single** ☐ **Employee + One Dependent** ☐ **Family**

C. COVERAGE WAIVER (See Special Enrollment on reverse)

☐ Waive Enrollment — I do not want (Check all that apply) ☐ Medical ☐ Dental ☐ Vision ☐ Drug

D. ENROLLED MEMBERS

Add	Drop	Relationship	Last Name	First Name, MI	Birth Date	Social Security No.	Gender Male	Gender Female	Benefit Selection Medical	Dental	Vision	Drug
☐	☐	Employee			/ /		☐	☐	☐	☐	☐	☐
☐	☐	Spouse/ DP			/ /		☐	☐	☐	☐	☐	☐
☐	☐	Child*			/ /		☐	☐	☐	☐	☐	☐
☐	☐	Child*			/ /		☐	☐	☐	☐	☐	☐
☐	☐	Child*			/ /		☐	☐	☐	☐	☐	☐
☐	☐	Child*			/ /		☐	☐	☐	☐	☐	☐

***Eligible dependents: spouse/domestic partner and child up to age 26. Extension available for child up to age 28 (taxable benefit). See plan document for details.**

Is any child over the dependent age limit applying for coverage due to a disability? ☐ No ☐ Yes, Dependent's Name: _____

E. PRIOR AND OTHER COVERAGE INFORMATION (including Medicare)

If yes, who was covered? ☐Employee ☐ Spouse/DP ☐Dependent children Date coverage began____/_ /___ Date ended___/___/____

F. OTHER COVERAGE INFORMATION (including Medicare)

Policy holder Name(s):	Medical Ins. Co. Name:	ID or Policy Number	Other Coverage applies to:
			☐ Employee ☐Med ☐Dental ☐Vision ☐Drug ☐ Spouse/DP ☐Med ☐Dental ☐Vision ☐Drug ☐ Child(ren) ☐Med ☐Dental ☐Vision ☐Drug

Please see reverse side.

Terms and Conditions

I hereby apply for the coverage indicated on this application:

I authorize: (1) payroll deduction(s) and remittance of any required contribution for my coverage to Medical Mutual, any affiliates or division of medical Mutual, and/or the sponsor of my group Health plan; (2) release of information, without limitation, from any medical/medically-related facility, prior health carrier, the Medical Information Bureau (MIB), 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 credentialing purposes. I authorize Medical Mutual and/or the sponsor of my group health plan 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.

My dependents and I understand and agree that any information obtained will not be release by Medical Mutual to any person or organization, except to reinsuring companies, the MIB, or other persons or organizations performing health care 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 information is disclosed pursuant to this authorization, it may be re-disclosed 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. My revocation must be in writing. The revocation will not apply to information that has already been released in response to this authorization. The revocation may adversely affect my Application or a pending insurance action.

I understand and acknowledge that this authorization extends to all medical records, including records that 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.

If applying for either a health maintenance organization (HMO) or point of service (POS) plan, I understand that: (1) Enrollee access is restricted to network health care providers: (2) I am required to have a network physician provide or arrange for all medical services (except maternity or life-threatening emergencies) to receive any benefits, in the case of an HMO plan, or the highest level of benefits, in the case of a POS plan; and (3) I will receive a list of plan physicians and plan facilities upon enrollment and/or request.

Special Enrollment

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may in the future be able to enroll yourself or your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer contributions toward your or your dependents' other coverage falls below the threshold specified in the Plan), and provided that you request enrollment within 31 days after your other coverage ends. If you have a new dependent as a result of a marriage, birth, adoption or placement for adoption, you will 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. If you or your dependent either become eligible for premium assistance or lose eligibility for coverage under the State Children's Health Insurance Program (SCHIP), you will also be able to enroll in this plan. However, you must request enrollment within 60 days after such an event.

Waiver

In the event that I have elected to waive health coverage on this Form, I hereby recognize and acknowledge that such waiver shall continue to remain in effect until I affirmatively elect health coverage (either as a result of a special enrollment opportunity or during open enrollment). I understand that in the event that I fail to make an affirmative election for health coverage in future open enrollment periods, my election to waive coverage shall remain in effect.

Signature

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

Employee Signature_____**Date signed**_____/_____/_____

Note: Any person who, with intent to defraud or knowing that he 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)

Agreement to Save Taxes on Insurance Premiums

☐ **YES** I agree to have my share of the premium for these employee benefits automatically paid with pre-tax dollars. I also understand that if my required contributions for these insurance benefits are increased or decreased while this agreement is in effect, my taxable income will automatically be adjusted to reflect that change**.**

☐ **NO** I decline this option for this plan year and understand that I will lose all tax savings that I could receive as a participant.

I understand that I may change my election in the event of certain changes in my status and that, prior to the first day of each plan year; I will be offered the opportunity to change my benefit election for the upcoming plan year.

Employee Signature_____**Date signed**_____/_____/_____