MEDICAL MUTUAL

Employee Enrollment / Change Form
(For Self-insured Groups Only)
(PLEASE USE BALL POINT PEN)

BASIC INFORMATION

☐ **New Enrollee** **Date of Hire** ____________________
☐ **Re-hire** **Date** ____________________
☐ **Coverage Change** **Date** ____________________

GROUP NO.:

SECTION NO.:

LEVEL OF BENEFITS: ☐ Single ☐ Family ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Two Persons ☐ Medicare Supplemental

EMPLOYMENT STATUS: ☐ Active ☐ Retired ☐ COBRA

EMPLOYEE CLOCK NUMBER:

EMPLOYEE DEPT. NO.:

PAYROLL LOCATION:

CHANGES: ☐ Add Dependents due to:
☐ Marriage ☐ Birth ☐ Adoption
☐ Drop Dependents Due To:
☐ Divorce ☐ Death ☐ Other ____________________

☐ New Name
☐ New Address
☐ Change to Medicare Elig.
☐ Change Coverage

☐ Other ____________________

DATE OF EVENT: MO. DAY YR.

COV. OR CHANGE EFF. DATE: MO. DAY YR.

Last Name	First Name	M Initial	E-mail Address

Street Address	City	State	Zip	Phone No.

Employee Date of Birth MO. DAY YR.

Sex ☐ M ☐ F

Employee Social Security Number

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legal Separation

Date Married MO. DAY YR.

Employer or Group Name

Date of Hire-Full Time MO. DAY YR.

Job Title

Check Coverage Desired: ☐ **Health: Benefit Option or Product Desired** ____________________ ☐ Prescription Drug ☐ Dental ☐ Vision

For HMO and Point-of-service plans: Primary Care Physician (PCP) Name ____________________ State________ Current Patient? ☐ YES ☐ NO

PCP Name for Dependents (if different than above): ____________________

MEDICARE INFORMATION

Are you covered by Medicare? ☐ YES ☐ NO If YES, Medicare No. ____________ Effective Date: ____________ ☐ Hemodialysis

Is your spouse covered by Medicare? ☐ YES ☐ NO If YES, Medicare No. ____________ Effective Date: ____________ ☐ Hemodialysis

OTHER INSURANCE INFORMATION

DO YOU OR ANY OF YOUR DEPENDENTS HAVE ANY OTHER HEALTH OR DENTAL COVERAGE? ☐ **YES** ☐ **NO** **IF YES, COMPLETE THE SECTION BELOW.**

NAME OF POLICY HOLDER	NAME AND ADDRESS OF OTHER INSURANCE COMPANY	POLICY NUMBER	EFFECTIVE DATE	COVERAGE TYPES	WORK STATUS	POLICY TYPE
			/ /	☐Medical ☐Dental ☐Hospital Only ☐Vision ☐Prescription Drug	☐ Active ☐ Retired	☐ Single ☐ Family
			/ /	☐Medical ☐Dental ☐Hospital Only ☐Vision ☐Prescription Drug	☐ Active ☐ Retired	☐ Single ☐ Family

What date did your most recent health insurance program become effective (check box if no prior/current coverage)?_____/_____/_____ ☐ No coverage

What date did/will this health insurance program terminate (check box if no prior/current coverage)?_____/_____/_____

DEPENDENT INFORMATION

RELATIONSHIP	BIRTHDATE	SEX	LAST NAME (ONLY IF DIFFERENT)	FIRST NAME	SOC. SEC. NO.	OVER AGE DEPENDENT STATUS
Spouse	MO. DAY YR.	☐M ☐F				
☐ Child ☐ Adopted ☐ Stepchild ☐ Other[1]		☐M ☐F				☐ F/Time Student ☐ Lv/Ab Health ☐ Disabled Medicare Elig.; ☐ Hemodialysis ☐ Disability
☐ Child ☐ Adopted ☐ Stepchild ☐ Other[1]		☐M ☐F				☐ F/Time Student ☐ Lv/Ab Health ☐ Disabled Medicare Elig.; ☐ Hemodialysis ☐ Disability
☐ Child ☐ Adopted ☐ Stepchild ☐ Other[1]		☐M ☐F				☐ F/Time Student ☐ Lv/Ab Health ☐ Disabled Medicare Elig.; ☐ Hemodialysis ☐ Disability
☐ Child ☐ Adopted ☐ Stepchild ☐ Other[1]		☐M ☐F				☐ F/Time Student ☐ Lv/Ab Health ☐ Disabled Medicare Elig.; ☐ Hemodialysis ☐ Disability

1. Legal Documentation (court decree, guardianship papers, etc.) must be attached to this application if relationship is marked other.

DISTRIBUTION: **WHITE-MM** **CANARY-Marketing** **PINK-Group**

Z7365 R9/14

TERMS AND CONDITIONS

I hereby request enrollment in the coverage indicated on this enrollment form.

I authorize: (1) payroll deduction(s) and remittance of any required contribution for my coverage to 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 Services (Medical Mutual): (a) to evaluate this enrollment form; (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 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 enrollment form.

My dependents and I understand and agree that any information obtained will not be released by Medical Mutual and/or sponsor of my group health plan 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 enrollment form, 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 enrollment or a claim.

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 enrolling in 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.

SIGNATURE

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

_____ _____

Employee Signature Date

WAIVER

COMPLETE THE WAIVER SECTION BELOW ONLY if you do not want any coverage or want to waive some of the coverage options.

A. Waived coverages: I do not want (Check all that apply)

☐ Self: ☐ Health ☐ Drug ☐ Dental ☐ Vision through Medical Mutual®

☐ Dependent: ☐ Health ☐ Drug ☐ Dental ☐ Vision through Medical Mutual for the following spouse and/or dependent(s) only:

1 _____ 2 _____ 3 _____ 4 _____ 5 _____

Please indicate reason for waiving coverage:

☐ No coverage

☐ Employee/dependent has existing coverage. Insurance company name: _____

B. Terms and Declarations:

I understand that if I check any box in Question A of this Waiver, I am choosing not to have those persons covered under the health coverage designated, and any later request 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 insurance coverage, you may be able to enroll yourself or your dependents in this plan if: (1) you or your dependents lose eligibility for that other coverage or reach the plan's lifetime benefit maximum; or (2) the employer stops contributing towards you or your dependents' other coverage. However, you must request enrollment within 31 days after the applicable event occurs (other coverage ends, lifetime maximum is met, or employer's contribution ends). 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. In addition, if you have a new dependent as a result of 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.

I have read and understand the above terms:

Current Employer: _____

Print Employee Name: _____

Print Spouse Name: _____

Employee Signature: _____ Date: _____

WARNING: If you or your family members are covered by more than one healthcare 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.