COSE BENEFIT PLAN

Employee Application/Change Form For Groups with 1-50 Employees

Section I: HEALTH INSURANCE WAIVER

I understand that if I check any box in Part 1 of this waiver I am choosing not to have those persons covered under the health insurance designated.

Part 1: Waived Coverages: I do not want coverage for (Check all that apply)

Myself	☐ Medical	☐ Dental	☐ Vision	☐ Life/Disability
Spouse or Domestic Partner	☐ Medical	☐ Dental	☐ Vision	☐ Life/Disability
Child(ren)	☐ Medical	☐ Dental	☐ Vision	☐ Life/Disability

Please list name(s) of spouse/domestic partner and/or child(ren) for whom coverage is being waived:

_____

Part 2: Reason for waiving coverage: (Check appropriate waiver type)

☐ Covered by spouse/domestic partner or parent's employer coverage

Name of Insurer: _____

☐ Medicare ☐ TRICARE ☐ VA coverage ☐ Medicaid

☐ Individual – My policy was obtained through an exchange **and** I was approved for a subsidy

Name of Insurer: _____

☐ Enrolled in another employer's group plan as an employee or retiree

Name of Insurer: _____

☐ Other:_____ ☐ No coverage

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance coverage or group health plan coverage, you may 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 stops contributing toward you or your dependents other coverage). However, you must request enrollment within 30 days after you or your dependent's other coverage ends (or after the employer stops contributing toward other coverage). If you or your dependent either becomes eligible for premium assistance or lose eligibility for coverage under the States Children's Health Insurance Program (SCHIP), you will be able to enroll in this plan. However you must request enrollment within 60 days after such event. 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. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

I have read and understood the above terms:

Current Employer _____ Group Number _____

Print Employee 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.

Employee Name	Group/Company Name
Social Security #	Group #/Section # (required)

COSE BENEFIT PLAN

Section II: ACTION REQUIRED

☐ New Application ☐ COBRA/Continuation ☐ Policy Change ☐ Change to Medicare Eligibility

Select Coverage: (check all that apply)

☐ Health/Drug Product Name _____

☐ Dental* Product Name _____

☐ Vision* Product Name _____

*Dental/Vision benefits are fully-insured through Medical Mutual

Qualifying event date: _____

Action: (check type of change)

☐ Add dependent to the policy due to: (list dependents in section III) ☐ Birth ☐ Adoption

☐ Delete dependent from policy due to: (list dependents in section III) ☐ Divorce ☐ Death ☐ Other_____

☐ Add spouse due to marriage (list Spouse in section III) Date married: _____

☐ Name change (list new name in section III) Former name: _____

☐ Address change (enter new address in Section III)

☐ Cancel coverage

☐ Other (description) _____

Section III: APPLICANT INFORMATION

Last Name	First Name	MI
Permanent Residence	City	E-mail Address

County	State	Zip Code	Best Contact # ( )	Alternate # ( )

Employment Status ☐ Active, **Full Time Date of (Re)Hire:** _____

☐ Retired

☐ COBRA, Expiration Date: _____

Marital Status

☐ Single

☐ Married

Employee Clock Number:	Employee Dept. Number:	Payroll Location:

Relationship	First Name, MI (and last name, if different)	Social Security Number[2]	Birth Date	Gender	Height/ Weight	Primary Care Physician (HMO Only)	Tobacco User[3]
Self				☐ M ☐ F			☐ **Y** ☐ **N**

What is your race or ethnicity? *(Select all that apply)*

☐American Indian or Alaska Native - I ☐Asian - A ☐Black or African American - B ☐Hispanic, Latino, or Spanish origin - H

☐Native Hawaiian - J ☐Caucasian - C ☐Other Pacific Islander - P ☐Not Provided - 7

Spouse				☐ M ☐ F			☐ **Y** ☐ **N**

What is your race or ethnicity? *(Select all that apply)*

☐American Indian or Alaska Native - I ☐Asian - A ☐Black or African American - B ☐Hispanic, Latino, or Spanish origin - H

☐Native Hawaiian - J ☐Caucasian - C ☐Other Pacific Islander - P ☐Not Provided - 7

Domestic Partner[1]				☐ M ☐ F			☐ **Y** ☐ **N**

What is your race or ethnicity? *(Select all that apply)*

☐American Indian or Alaska Native - I ☐Asian - A ☐Black or African American - B ☐Hispanic, Latino, or Spanish origin - H

☐Native Hawaiian - J ☐Caucasian - C ☐Other Pacific Islander - P ☐Not Provided - 7

Employee Name		Group/Company Name
Social Security #		Group #/Section # (required)

COSE BENEFIT PLAN

Section III: APPLICANT INFORMATION continued

Dependent Child[2]				☐ M ☐ F			☐ Y ☐ N

What is your race or ethnicity? *(Select all that apply)*

☐ American Indian or Alaska Native - I ☐ Asian - A ☐ Black or African American - B ☐ Hispanic, Latino, or Spanish origin - H
☐ Native Hawaiian - J ☐ Caucasian - C ☐ Other Pacific Islander - P ☐ Not Provided - 7

Dependent Child[2]				☐ M ☐ F			☐ Y ☐ N

What is your race or ethnicity? *(Select all that apply)*

☐ American Indian or Alaska Native - I ☐ Asian - A ☐ Black or African American - B ☐ Hispanic, Latino, or Spanish origin - H
☐ Native Hawaiian - J ☐ Caucasian - C ☐ Other Pacific Islander - P ☐ Not Provided - 7

Dependent Child[2]				☐ M ☐ F			☐ Y ☐ N

What is your race or ethnicity? *(Select all that apply)*

☐ American Indian or Alaska Native - I ☐ Asian - A ☐ Black or African American - B ☐ Hispanic, Latino, or Spanish origin - H
☐ Native Hawaiian - J ☐ Caucasian - C ☐ Other Pacific Islander - P ☐ Not Provided - 7

[1] Refer to Section VIII, Number 13, Terms and Conditions, for domestic partner eligibility requirements.
[2] Providing Social Security Number will maximize claims accuracy and expedite processing.
[3] Tobacco User 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 IV: OTHER COVERAGE

Medicare Information Are you or any dependent covered by Medicare? ☐ Yes ☐ No If yes, please complete the section below:

Policyholder Name	Medicare Number	Part A Effective Date	Part B Effective Date	Reason for Medicare
				☐ Age ☐ End Stage Renal ☐ Disability, Indicate Reason: ____________
				☐ Age ☐ End Stage Renal ☐ Disability, Indicate Reason: ____________

Important Notice for Medicare Eligible Individuals: If you are entitled to Medicare and Medicare is your primary coverage, you should enroll in and maintain that coverage, because when the COSE Benefit Plan ("MEWA') is the secondary payer to Medicare Part B, the MEWA will coordinate benefits as if you were covered under Part B, even if you are not. This can result in you being responsible for costs that would have been paid by Medicare. Your broker can assist you with any questions.

Continuing Coverage (other than Medicare) Are you or any dependent keeping other or dental health insurance coverage?
☐ Yes ☐ No If yes, please complete the section below:

Policyholder Name	Name and Address of Insurance Company	Policy Number	Effective Date	Coverage Type	Work Status	Policy Type
				☐ Medical ☐ Dental ☐ Hospital Only ☐ Vision ☐ Prescription Drug	☐ Active ☐ Retired	☐ Single ☐ Family

Section V: ABOUT YOUR NEEDS

If you have a special language or other cultural need that may affect the administration of your health plan or healthcare delivery, please indicate below so that Medical Mutual may better assist you:

Y	N	
☐	☐	Hearing-impaired (Require use of TDD/TYY or other means of communication)
☐	☐	Vision-impaired (Require audio communication or large print document)
☐	☐	Speak a primary language other than English (Require interpretive services) please list language:____________
☐	☐	Other cultural need/preference:____________________________

Employee Name	Group/Company Name
Social Security #	Group #/Section # (required)

COSE BENEFIT PLAN

Section VI: MEDICAL HEALTH QUESTIONNAIRE

Prior claims history may not be reviewed in the medical underwriting process. It is important that all conditions are disclosed for accurate rating purposes.

A. MEDICAL CONDITIONS

Have you or any listed dependents in the past 5 years received consultation for, been treated for, diagnosed as having, or been recommended for future surgery, diagnostic testing (excluding HIV and AIDS) or medical treatment or thought you should seek medical advice for any of the following conditions? If yes, explain in Section C below.

A. Cancer
Y N
1. ☐☐ Cancer, Type _____
2. ☐☐ Lymph Node Involvement
3. ☐☐ Chemotherapy
4. ☐☐ Radiation

B. Lung/Respiratory
Y N
1. ☐☐ Allergies - Shots ☐Y ☐N
2. ☐☐ Asthma
3. ☐☐ Cystic Fibrosis
4. ☐☐ Emphysema – Oxygen ☐Y ☐N

C. Muscular/Skeletal
Y N
1. ☐☐ Degenerative Disc Disease
2. ☐☐ Fibromyalgia
3. ☐☐ Herniated Disc
4. ☐☐ Osteoarthritis Location: _____
5. ☐☐ Rheumatoid Arthritis
6. ☐☐ Joint Replacement
7. ☐☐ Spina Bifida

D. Heart/Circulatory
Y N
1. ☐☐ Aneurysm, Type _____
2. ☐☐ CAD/Angina
3. ☐☐ Angioplasty, Date _____
4. ☐☐ Bypass Surgery, Date _____
5. ☐☐ Congestive Heart Failure
6. ☐☐ Heart Attack, Date _____
7. ☐☐ Pacemaker/ICD Implant
8. ☐☐ Stroke, Date _____
9. ☐☐ Blood Clot Location: _____
10. ☐☐ Irregular Heart Beat
11. ☐☐ Peripheral Vascular
12. ☐☐ Anemia, Type _____
13. ☐☐ Other Blood Disorder Type _____
14. ☐☐ Hypertension
15. ☐☐ High Cholesterol
16. ☐☐ Heart Valve Disorder, Type _____

E. Endocrine
Y N
1. ☐☐ Diabetes (Type 1- Insulin)
2. ☐☐ Diabetes (Type 2- Oral)
3. ☐☐ Diabetes (Diet/Exercise)
4. ☐☐ Thyroid Disorder

F. Neurological
Y N
1. ☐☐ Cerebral Palsy
2. ☐☐ Epilepsy
   ☐ Grand Mal ☐ Petit Mal
   Date of Last Seizure _____
3. ☐☐ Multiple Sclerosis
4. ☐☐ Parkinson's Disease

G. Psychological
Y N
1. ☐☐ Depression/Anxiety
2. ☐☐ Bipolar/Schizophrenia
3. ☐☐ Hospitalized, Date _____
4. ☐☐ Suicide Attempt, Date ____
5. ☐☐ Alcohol or Drug Dependency

H. Urinary/Bowel/Reproductive
Y N
1. ☐☐ Abnormal Pap Date ____
2. ☐☐ Normal Follow-Up Pap Date _____
3. ☐☐ Colon Polyps/Diverticulitis
4. ☐☐ Crohn's/Ulcerative Colitis
5. ☐☐ Gastric Reflux/Ulcer
6. ☐☐ Enlarged Prostate
7. ☐☐ Kidney Stones
8. ☐☐ Reproductive Disorder
9. ☐☐ Polycystic Ovarian Syndrome
10. ☐☐ Endometriosis
11. ☐☐ Pregnant, Due Date: _____

I. Miscellaneous
Y N
1. ☐☐ End Stage Renal Failure
2. ☐☐ Transplant, Type _____
3. ☐☐ Hemophilia, Type_____
4. ☐☐ Lupus, Type_____
5. ☐☐ Hepatitis, Type _____
6. ☐☐ Other Immune Disorder, Type (excluding HIV/AIDS) _____

B. MEDICAL QUESTIONS

Y N
1. ☐ ☐ Are you or any dependent currently taking any prescription or over-the-counter medications? (Explain in Section C below.)
2. ☐ ☐ Within the past 5 years, have you or any dependent been hospitalized or had any type of surgery or been diagnosed as having any other condition/disorder/disease not listed above? (Explain in Section C below.)
3. ☐ ☐ Within the past 5 years, have you or any dependent been advised to have an operation and/or further treatment which has not yet been performed? (Explain in Section C below.)
4. ☐ ☐ Has ANY PERSON TO BE COVERED ever been diagnosed as having AIDS, or an AIDS related condition or had a positive test result on an HIV test?

C. EXPLANATION (Explain all *yes* responses from Medical Conditions and Medical Questions here)

Name	Condition Number	Treatment Date (From-To)	Recovered Diagnosis/Treatment/Medication/Dosage (Be specific)	Y N
John Doe	*eg. A5*	*10/2005-3/2007*	*Skin Cancer/Radiation/Medication Xxxxxxxx*	☑ ☐
				☐ ☐
				☐ ☐
				☐ ☐
				☐ ☐
				☐ ☐

Employee Name	Group/Company Name
Social Security #	Group #/Section # (required)

COSE BENEFIT PLAN

Section VII: PRODUCTS**

Life, Disability and MedMutual Extend Benefits

A. COVERAGE SELECTION

Your group insurance provided by MedMutual Life Insurance Company™ may not include all the benefits listed below. Ask your employer for the details about the benefits available to you, your cost, (if any), and whether you will be required to submit evidence of insurability.

Employer Paid Plans*

Elect	Waive	Coverage Type
☐	☐	Basic Life and AD&D
☐	☐	Dependent Life
☐	☐	Short-Term Disability
☐	☐	Long-Term Disability

Class and Salary Information

Life Class:

Occupation/Job Title:

Current Earnings: $

☐ Hour ☐ Month ☐ Week ☐ Year

*If employer pays 100% of premium, employee may not waive coverage

Employee Paid Plans**

Elect	Waive	Coverage Type	Amount
☐	☐	**Voluntary Life** (can be chosen in increments of $10,000, to a maximum of $300,000)	$ _____
☐	☐	**Supplemental Life**	$ _____
☐	☐	**Supplemental AD&D**	$ _____
☐	☐	**Dependent Life**	$ _____

B. VOLUNTARY STD PLAN OPTIONS

Plan	Weekly Benefit	Min. Annual Salary	Plan	Weekly Benefit	Min. Annual Salary	Plan	Weekly Benefit	Min. Annual Salary
☐ 1	$100	$7,430	☐ 4	$250	$18,570	☐ 7	$400	$29,715
☐ 2	$150	$11,140	☐ 5	$300	$22,285	☐ 8	$450	$33,430
☐ 3	$200	$14,860	☐ 6	$350	$26,000	☐ 9	$500	$37,145

C. BENEFICIARY DESIGNATION (For Employee Only: Must be completed if you have applied for Life or AD&D insurance).

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%. (Employee is the beneficiary of proceeds from spouse or child coverage).

Last Name	First Name	Date of Birth	Relationship	Benefit %
Primary:				
Primary:				
Contingent:				
Contingent:				

D. MEDMUTUAL EXTEND

- ☐ Premium
- ☐ Preferred
- ☐ Select
- ☐ Critical Illness
- ☐ Accident
- ☐ Critical Illness/Accident

Employee Name	Group/Company Name
Social Security #	Group #/Section # (required)

COSE BENEFIT PLAN

Section VIII: TERMS AND CONDITIONS

1. I hereby apply to the COSE Benefit Plan [(MEWA)]. I acknowledge that I am applying for an employee health benefit offered collectively through the MEWA under a certificate of authority issued by the Ohio Department of Insurance and that this benefit may be subject to special terms and conditions outlined by the MEWA Summary Plan Description and Plan Document as amended from time to time by the Greater Cleveland Partnership.

2. I understand that the dental and vision benefits made available through the MEWA are fully insured by Medical Mutual ("Medical Mutual"). I understand that the life, AD&D, disability fixed indemnity and accident-only benefits made available through the MEWA are fully insured by MedMutual Life Insurance Company ("MedMutual Life").

3. I authorize (1) payroll deduction(s) and remittance of any required contribution for coverage to the MEWA and/or any affiliates, contracted third party administrators, and representatives; (2) release of information, without limitation, from any medical/medically related facility, prior health insurance carrier, the Medical Information Bureau, Inc. (MIB), prescription history database supplier, government agency or person to the MEWA, its Plan Administrator, and Medical Mutual/ MedMutual Life and/or any affiliates, pharmacy benefit manager, third party administrator, reinsurance companies, agents and representatives; (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 the MEWA, its Plan Administrator, and/or Medical Mutual/MedMutual Life 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.

4. By signing below, I represent and warrant as follows: (a) I have thoroughly read and understand this Application and the questions asked herein; (b) I am solely and exclusively responsible for the truth, accuracy and completeness of all of the answers contained in this Application; (c) I have answered every Application question set forth in this Application; (d) all of my answers to each of the questions are accurate, complete and true; and (e) I did not sign a blank or partially completed Application.

5. 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 to any portion of any answer to any question on this Application or any information the MEWA, its Plan Administrator, and/or Medical Mutual/MedMutual Life 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 benefits that are inconsistent with, or different from, any written information provided by the MEWA or its Plan Administrator; (d) to bind the MEWA 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 coverage under a policy; (e) to answer any questions in, or insert any information on, this Application on my behalf; or (f) to approve my enrollment in the MEWA. All contract terms must be in writing and signed or accepted in writing by an authorized representative of the MEWA's Board of Trustees. The applicable certificate or evidence of coverage will determine the rights and responsibilities of covered person and will govern in the event they conflict with any benefit comparison summary or other description of the plan.

6. 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 the MEWA, and its Plan Administrator, and/or Medical Mutual/MedMutual Life have 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.

7. I agree that any untrue or incomplete information, statement or answers on this Application can result in denial of a claim and that any intentional misrepresentation of material fact or fraud in this Application can result in rescission of coverage and may subject me to legal action by the MEWA and/or Medical Mutual/MedMutual Life.

8. I understand that I must notify Medical Mutual, in writing, immediately if I (the applicant) or any other person for whom coverage is sought receives medical treatment, advice, care or a diagnosis for any illness, injury or condition after the date I sign this application but before my coverage approval date. I understand that in this situation, Medical Mutual has the right to underwrite my application again, using the new information and that, as a result , my coverage/family member's coverage might be rescinded or delayed or benefits denies due to the illness, injury or condition being treated as a preexisting condition.

Continued on page 7

Employee Name	Group/Company Name
Social Security #	Group #/Section # (required)

COSE BENEFIT PLAN

Section VIII: TERMS AND CONDITIONS (continued)

9. To be eligible for coverage, I must be an active full-time employee as defined by the plan documents.

10. I understand that in order to be eligible for coverage through the MEWA, I must meet the eligibility requirements set forth in the plan documents of the MEWA and: 1) for coverage as an employee, I must be an active, full-time employee drawing a regular paycheck; and 2) for life, AD&D, disability, dental, vision, fixed indemnity and/or accident-only coverage, I must also meet the eligibility requirements of Medical Mutual/MedMutual Life; to be eligible for such coverage, I must be an active full-time employee as defined by the group participation agreement.

11. My dependents and I understand and agree that any information obtained will not be released by the MEWA, its Plan Administrator, or Medical Mutual/MedMutual Life to any person or organization except to reinsuring companies, the MIB, or other person 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 (including medical, dental and pharmacy) 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 request. A photographic copy of this authorization shall be 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 the Offices of the MEWA's Board of Trustees. 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 the MEWA's Board of Trustees. Your refusal to authorize release of information may impact your ability to enroll in the COSE Benefit Plan if Medical Mutual needs this information to determine your eligibility for coverage.

12. 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.

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. The MEWA for which I am applying is a self-insured plan, and benefits are not guaranteed by a licensed insurer. The MEWA is not covered by the Ohio Life and Health Guaranty Association. This is a fully assessable benefit plan. In the event that the multiple employer self-insured health plan is unable to pay its obligations, participating employers shall be required to contribute on a joint and several basis the funds necessary to meet any unpaid obligations. The Plan does provide certain protections to Plan Sponsors regarding this assessment. Certain other major protections offered to Ohio residents under the Ohio Insurance Code and Rules and Regulations, such as conversion rights and certain mandated or required benefits, may not be available through the multiple employer self-insured plan.

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 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. I understand that I should not cancel any current coverage until I receive an approval letter and certificate of coverage from the MEWA.

Employee Signature _____ 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).

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