cose
council of smaller enterprises

MEDMUTUAL LIFE™
A Medical Mutual Company

APPLICATION/PARTICIPATION AGREEMENT

Group Number

PART 1: APPLICANT INFORMATION

1. Business Name

Check if applicable:
- ☐ Partnership
- ☐ LLC
- ☐ Subchapter S Corp.
- ☐ Sole Proprietorship

2. Mailing Address (not P.O. Box)

Group Contact | Phone ( )

City | State | Zip | Fax ( )

3. Name of any ☐ Affiliates ☐ Subsidiaries to be covered | e-mail

4. Nature of Business | 5. SIC Code | 6. Effective Date | 7. Initial Rates Guaranteed for _____ months

8. Contributions: **Employer** will contribute:

Life/AD&D	☐ 100%	☐ Other_____ %
Voluntary Life	☐ 100%	☐ Other_____ %
STD	☐ 100%	☐ Other_____ %
Voluntary Short-Tern Disability	☐ 100%	☐ Other_____ %
Dependent Life	☐ 100%	☐ Other_____ %
Long-Term Disability	☐ 100%	☐ Other_____ %

9. Waiting Period
_____
_____
_____
_____

10. Waiting Period applies to:
- ☐ All employees
- ☐ New employees only

11. Total eligible employees _____
Total enrolled _____

12. Billing Method:
- ☐ List Billed
- ☐ TPA Billed
- ☐ Self Administered

13. Premium Deposit: (approx. one month's Premium)
$_____

14. Premium Payable: ☐ Monthly
☐ Other _____

15. ☐ Premium is due on the 1ST day of each billing period.
☐ Other _____

16. Is any other coverage in force or being applied for as of the effective date of coverage with MedMutual Life Insurance Company?

☐ Yes ☐ No If yes, please explain _____

PART 2: SCHEDULE OF BENEFITS

CLASS DEFINITIONS (if more than one class, definitions must be specific)

Class 1 _____
Class 2 _____
Class 3 _____
Class 4 _____

Employees working less than _____ hours per week are not eligible for coverage unless otherwise noted above.

SELECTION OF COVERAGE(S) (check all that apply and fill in all applicable blanks.)

Class	☐ Basic Life Insurance Amount of Insurance	☐ Basic AD&D Principal Sum	☐ Short-Term Disability Maximum Weekly Benefit
1			
2			
3			
4			

1. Weekly STD benefit is subject to a maximum of _____% of employee's Basic Weekly Wage.
2. STD Benefits Payable: _____ day of Accident; _____ day of Sickness for a maximum benefit period of _____ weeks.
3. STD Benefits payable for non-occupational disabilities only.
4. All benefits terminate at retirement unless otherwise noted in class definitions section.
5. STD Benefits not available for employees working in CA, HI, NJ, NY, PR or RI.

SELECTION OF COVERAGE(S) (continued) (check all that apply and fill in all applicable blanks.)

6. Life or AD&D benefits include 24 hour coverage.

7. If Life or AD&D benefits are based upon a multiple of salary, benefits amounts should be rounded to:

☐ the next higher multiple of $1,000 ☐ the nearest multiple of $1,000 ☐ other _____

8. Basic Life and AD&D benefits reduce by:

☐ 50% at age 70; and further reduces to 25% of the face amount at age 75.

☐ ___% at age ____; and further reduces to ___% of the face amount at age ____; and further reduces to ___ % of the face amount at age _____.

9. Voluntary Life benefits terminate at retirement.

☐ **Group Long-Term Disability**
*Employees must work a minimum of 30 hours per week

Select One Plan:

☐ 90 day elimination ☐ 180 day elimination ☐ Other _____

Dependent Life Insurance

*if a full time student(s) and dependent upon the insured insured

☐ Standard Option	☐ Other Option
Spouse: $ 5,000	Spouse: $_____
Child(ren):	Child(ren):
$ 0 Live birth but less than 14 days	$_____ Live birth but less than 14 days
$ 100 Age 14 days but less than 6 months	$_____ Age 14 days but less than 6 months
$ 5,000 Age 6 months but less than 21 years	$_____ Age 6 months but less than 21 years
$ 5,000 Age 21 years but less than 25 *	$_____ Age 21 years but less than _____ *

☐ **Voluntary Life Insurance**
Increments of $10,000 to a maximum of $300,000

☐ **Voluntary Short-Term Disability**
Increments of $50; minimum of $100 to a maximum of $500, not to exceed 70% of employee's Basic Weekly Wage.

Select One:

☐ Voluntary STD benefits payable: 1st day of Accident; 8th day of Sickness for a maximum benefit period of 26 weeks.

☐ Voluntary STD benefits payable: 15th day of Accident; 15th day of Sickness for a maximum benefit period of 26 weeks.

NON-MEDICAL MAXIMUM (amounts in excess of the amount stated are subject to satisfactory evidence of insurability)

Life: Basic $_____ Voluntary $ _____ Combined Basic and Voluntary $_____

STD: $ _____

PART 3: ACTIVE WORK

It is understood and agreed that this application shall be made part of the Policy for which application is made. It is further understood:

1. Being **Actively at Work** is a requirement for coverage. If an employee is **not Actively at Work** on the day his coverage would otherwise be effective, the effective date of his coverage will be the date of his return to **Active Work**. If an employee does not return to **Active Work**, he will not be covered.
   The terms **"Actively at Work"** and **"Active Work"** mean that an employee is performing the Material and Substantial Duties of his occupation; is working the number of hours specified in Part 2, Schedule of Benefits; and satisfies any other conditions required by the applicable group Policy.
2. As of the proposed effective date (Item 6 above), are any of your employees **not Actively at Work** (as defined above) **and, therefore, not eligible for coverage?**

   ☐ Yes ☐ No If yes, please provide the following information: (Attach a signed dated sheet if more space is needed.)

A. Name_____ Sex _____ Date of Birth _____ Date Last Worked _____

Reason not Actively at Work: ☐ Disability ☐ Family Leave ☐ Other _____

B. Name_____ Sex _____ Date of Birth _____ Date Last Worked _____

Reason not Actively at Work: ☐ Disability ☐ Family Leave ☐ Other _____

PART 4: TERMS AND CONDITIONS

I, as the undersigned employer or other eligible membership organization ("Participating Employer"), hereby apply for coverage in the Council of Smaller Enterprises (COSE), a division of Greater Cleveland Partnership (GCP), group association insurance policy offered by MedMutual Life Insurance Company (MedMutual Life). I acknowledge that a copy of the group insurance policy is available at COSE's office for review by Participating Employers and employees. I acknowledge that no coverage can commence unless I receive written notice from MedMutual Life's home office.

I agree that, upon acceptance and approval by MedMutual Life, I will, so long as such participation continues, fully comply with all obligations applicable to Participating Employers under the COSE policy as set forth therein. I understand that the insurance coverages under the group insurance policy will be only as provided for under the policy issued to COSE as the Policyholder. I acknowledge that COSE is not an insurer, and has no obligations regarding payment of premiums or handling of claims for the insurance provided under the group insurance policy issued to it as policyholder.

I understand that this insurance is subject to the approval of MedMutual Life, and nothing contained herein shall be binding upon MedMutual Life until this application is approved and accepted at MedMutual Life's home office. No waiver or change will bind MedMutual Life unless signed by an Executive Officer of MedMutual Life.

I certify that the information in this application is true and accurate to the best of my knowledge. I understand that the information in this application and any other information I provide shall serve as the basis for the coverage to be issued, and that I have a duty to notify MedMutual Life of any changes. I have relied upon no oral or written representations that contradict the aforementioned active-work information.

_____
Participating Employer Name

_____
Authorized Representative's Signature

_____
Title Date

WARNING: 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)

_____
Licensed Resident Agent (if required) Signature Date

Multi-Language Interpreter Services & Nondiscrimination Notice

MEDICAL MUTUAL®

This document notifies individuals of how to seek assistance if they speak a language other than English.

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 1-800-382-5729 رقم هاتف الصم والبكم 711).

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).

Navajo

Díí baa akó nínízin: Díí saad bee yáníłti' go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 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).

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-382-5729 (TTY: 711).

Please Note: Products marketed by Medical Mutual may be underwritten by one of its subsidiaries, such as Medical Health Insuring Corporation of Ohio or MedMutual Life Insurance Company.

Order Number: Z8188-MCA R4/19
Dept of Ins. Filing Number: Z8188-MCA R9/16

QUESTIONS ABOUT YOUR BENEFITS OR OTHER INQUIRIES ABOUT YOUR HEALTH INSURANCE SHOULD BE DIRECTED TO MEDICAL MUTUAL'S CUSTOMER CARE DEPARTMENT AT 1-800-382-5729.

Nondiscrimination Notice

Medical Mutual of Ohio complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex in its operation of health programs and activities. Medical Mutual does not exclude people or treat them differently because of race, color, national origin, age, disability or sex in its operation of health programs and activities.

- Medical Mutual provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, etc.).
- Medical Mutual provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services or if you believe Medical Mutual failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, with respect to your health care benefits or services, you can submit a written complaint to the person listed below. Please include as much detail as possible in your written complaint to allow us to effectively research and respond.

Civil Rights Coordinator
Medical Mutual of Ohio
2060 East Ninth Street
Cleveland, OH 44115-1355
MZ: 01-10-1900

Email: CivilRightsCoordinator@MedMutual.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights.

- Electronically through the Office for Civil Rights Complaint Portal available at:
  ocrportal.hhs.gov/ocr/portal/lobby.jsf
- 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:
  1-800-368-1019 (TDD: 1-800-537-7697)
- Complaint forms are available at:
  hhs.gov/ocr/office/file/index.html

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