

TO: SuperMed One Broker or Agent

RE: SuperMed One Application



FROM: _____

PHONE: _____

Thank You

Medical Mutual appreciates your interest in our SuperMed One products. You will find that our SuperMed One products offer you the best dependable coverage at the best value.

Enrollment Instructions

If you need assistance at any time during the enrollment process, call: 1-800-722-7331

To begin the SuperMed One enrollment process, you will need to complete the Health & Life Application/Change Form. Please print clearly using a blue or black ballpoint pen. After carefully reading each section and answering all questions, be sure to sign and date the application. All applications will be considered invalid 60 days after the signature date.

The completed application can be faxed or mailed to a SuperMed One broker or agent. If you currently have a health insurance broker or agent, please forward the application to the attention of that individual.

If you do not currently have an agent or broker, please forward the application via mail or fax to:

SuperMed One
P.O. Box 239
Litchfield, Ohio 44253
Toll free: 1-800-722-7331
Fax: 330-721-8815

Once received by a broker or agent, your application will be reviewed to ensure that all information is accurate and all questions completed. Your application will be sent to Medical Mutual's Underwriting Department for further review. Within five to seven days, your broker or agent will notify you of your acceptance and your actual monthly premium or denial. At that time, if you accept the approved premium rates and would like to continue, your application will be processed and you will receive a bill for the premium due.

Please Note

Do not cancel any current health insurance coverage until you receive an approval letter and insurance policy, also known as insurance contract or certificate, from Medical Mutual. Make sure you understand and agree with the term of the policy. Pay special attention to the effective date, premium amount, benefits, limitations, exclusions, and riders.

The rates quoted are estimates only, and are subject to change based on your medical history, the underwriting practices of Medical Mutual of Ohio, the optional benefits you selected, if any, and other relevant factors. Medical Mutual of Ohio reserves the right to change the terms of the policy under proper notification.



MMO USE ONLY
EFFECTIVE DATE: ____/____/____
GROUP NO.: _____

HEALTH & LIFE APPLICATION/CHANGE FORM

INSTRUCTIONS: All questions must be answered. Incomplete applications will be returned.

SECTION I: CONTRACT HOLDER INFORMATION

Last Name	MI	First Name	SS Number
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed		Marriage Date	Divorce Date
Permanent Residence		Email Address	City
County	State	Zip Code	Area Code and Phone Number

Reason for Application: Applying for New Coverage Applying for Dependent Only Coverage Applying for a Change to Current Coverage

LIST BELOW ALL INDIVIDUALS TO BE COVERED

	First Name, MI (and Last Name if different)	SS Number	Birth Date	Sex	Height	Weight	Smoker (circle)	Physician
Self			/ /		' "		Y N	
Spouse			/ /		' "		Y N	
1			/ /		' "		Y N	
2			/ /		' "		Y N	
3			/ /		' "		Y N	

SECTION II: FEDERAL AND OHIO OPEN ENROLLMENT ELIGIBILITY

1. Are you a Federally Eligible Individual or applying for coverage under the Ohio Open Enrollment requirements? Yes No

If Yes, **STOP HERE.** SuperMed One is NOT a Federally Eligible or Ohio Open Enrollment product. For an information and application packet, please call Medical Mutual at 1-800-242-1936. Please note: SuperMed One may affect your status as a federally eligible individual. Visit www.healthinsuranceinfo.net for A Consumer's Guide to Getting and Keeping Health Insurance.

SECTION III: PRODUCT

HEALTH INSURANCE

(Preferred Provider Organization Uses SuperMed Plus network):
Note: Health Insurance products are medically underwritten.

Desired effective date (when coverage is to begin): ____/____/____

- \$500/\$1,000 Deductible
- \$1,000/\$2,000 Deductible
- \$1,500/\$3,000 Deductible
- \$2,500/\$5,000 Deductible
- \$5,000/\$7,500 Deductible

- \$500/\$1,000 Deductible (Short-Term)

OPTIONAL RIDERS: (Can only be purchased along with health insurance)

- Maternity care with a maximum
- Maternity care without a maximum
- Prescription Drug without a maximum
- \$500 Professional Services

OPTIONAL COVERAGE:

- Dental¹
- Vision¹
- SaveWell¹
- Critical Illness Benefit²
 - Applicant: \$5,000 \$15,000 \$25,000
 - Spouse: \$5,000 \$15,000 \$25,000
- Life² (If selected, complete beneficiary designation section on next page)
 - Applicant: \$15,000 \$25,000 \$50,000
 - Spouse: \$15,000 \$25,000 \$50,000

¹ Can be purchased as a stand alone product. If purchased as stand alone product, one year of premium is due with payment of first bill.

² The critical illness and life insurance is underwritten by Medical Life Insurance Company. This product offering is only available if you are approved for Medical Mutual of Ohio permanent health insurance. It is not available with the short-term health product.

SECTION III: PRODUCT (continued)

Will this Life Insurance replace any existing insurance with this or any other company? Applicant: Yes No Spouse: Yes No

Name of Company _____

	APPLICANT'S BENEFICIARY DESIGNATION		SPOUSE'S BENEFICIARY DESIGNATION	
	PRIMARY	CONTINGENT	PRIMARY	CONTINGENT
First Name				
Last Name				
Date of Birth	/ /	/ /	/ /	/ /
Relationship				
S.S. Number				

SECTION IV: OTHER COVERAGE INFORMATION

1. Do **YOU**, your **SPOUSE** or any listed **DEPENDENT** have any other type of (Accident, Medicare, Medicaid, etc.) or are you currently applying for any other health insurance? Yes No If yes, please complete the following:

Name of Company	Name of Family Member with or applying for coverage
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2. If you were covered by another health plan within the last 63 days you may be eligible for credit of pre-existing condition limitation, except for SuperMed One Short Term. To qualify for credit, please complete the following.

Name of Insurance Company	Date of Coverage
	From To
Policy # (If Medical Mutual)	

SECTION VI: BILLING INFORMATION

CHOOSE ONE:

HOME – Receive monthly premium billings

FINANCIAL INSTITUTION – Have monthly automatic premium withdrawals

If you wish to be billed through your financial institution, please complete the following authorization:

I authorize Medical Mutual of Ohio to initiate premium deductions from my account. The authorization will remain in effect until Medical Mutual of Ohio and my financial institution have received written notification from me within a reasonable time period to allow termination of the deduction.

Premiums are to be deducted from: Checking Savings

(Please note: Not all Financial Institutions allow deductions from a savings account. Please verify this information with your financial institution.)

Name and branch of bank/financial institution (Must be in Ohio)			Account Number
Address			Account Holder's Name
City	State	Zip Code	Transit Routing Number:

Please attach a voided check for checking account or a deposit slip for savings account in order for our office to verify the bank information.

CREDIT CARD – Have monthly premium billed to credit card

If you wish to be billed through your credit card, please complete the following authorization: MasterCard Visa

Card Holder Name	Card Number
Bank Name (If applicable)	Expiration Date

 Account Holder's Signature

 Date

LIST BILLING THROUGH EMPLOYER – is available only to employees of a common employer who has agreed to collect the premiums on a monthly basis through payroll deduction and where the employer is not paying any portion of the premium.

Name of Employer		Occupation	
Address	State	Zip Code	Area Code and Phone Number

ATTACH VOIDED CHECK OR DEPOSIT SLIP HERE

FOR OFFICE USE ONLY

Sold - Account Executive and Code
Service - Account Executive and Code

or

Agent of Record India Network Services, Inc.	Tax ID
Royal Advantage Broker	Commission Indicator 96.15

