Huron–Erie School Employee Insurance Association
Employee Application/Change Form

MMO Group Number: 569036 Section #: _____

DELTA Group Number: 1306 Section #: _____

MMO Effective date: _____ DELTA Effective date: _____

EMPLOYEE INFORMATION

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

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 _____

C. COVERAGE WAIVER

☐ Waive Enrollment — I do not want to be enrolled in: ☐ Medical /Drug ☐ Dental

D. MEDICAL AND DENTAL ENROLLMENT

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 **			/ /		☐	☐	☐	☐	☐	☐
☐	☐	Child ☐☐ Step			/ /		☐	☐	☐	☐	☐	☐
☐	☐	Child ☐☐ Step			/ /		☐	☐	☐	☐	☐	☐
☐	☐	Child ☐☐ Step			/ /		☐	☐	☐	☐	☐	☐
☐	☐	Child ☐☐ Step			/ /		☐	☐	☐	☐	☐	☐
☐	☐	Child ☐☐ Step			/ /		☐	☐	☐	☐	☐	☐

Child over the dependent age limit applying due to a disability: Onset of Disability Date: Dependent's Name:

E. PRIOR AND OTHER COVERAGE INFORMATION (including Medicare) YES NO

If yes, who was covered? ☐Employee ☐ Spouse ☐Dependent children Date coverage began ___/___/___ Date ended ___/___/___

F. OTHER COVERAGE INFORMATION (including Medicare) ***ALL SPOUSES MUST COMPLETE A COB QUESTIONNAIRE***

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

SIGNATURE REQUIRED ON BACK

G. MEDICAL PLANS: Please select the Plan you want (Put an X beside your choice.

Please see reverse side.

$500 Deductible Plan ☐ **$750 Deductible Plan** ☐

Premium Savings Plan ☐ **Minimum Value Plan** ☐

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.

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 HESE 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)

Rev 9/28/21

REQUIRED DOCUMENTATION:
FOR SPOUSE:

Copy of marriage certificate; and
Copy of either (1) front page of federal tax return (2) recent household document (recurring monthly bill, bank statement; and Completed Working Spouse Certificate Form (if applicable)

FOR CHILDREN(Up to age 26 and disabled children)

Copy of child's birth certificate/hospital birth record or adoption certificate, or court order For stepchildren only, the above documentation for a spouse