

Coverage(s) will be provided by the Company(ies) indicated above. Healthcare benefits will be provided by Consumers Life Insurance Company. Life/Disability Income Insurance benefits will be provided by Fort Dearborn Life Insurance Co. (FDL).



## EMPLOYEE APPLICATION and CHANGE FORM

for individuals in  
Groups 20+ Eligible

### INSTRUCTIONS

- **PRINT CLEARLY USING A BLUE OR BLACK PEN (NO HIGHLIGHTERS)**
- **NEW HIRES, LATE ENTRANTS AND DEPENDENT ADDITIONS MUST COMPLETE THE APPLICATION INCLUDING GROUP NUMBER AND MEDICAL HISTORY QUESTIONNAIRE.**
- **CHANGES TO AN EXISTING POLICY, COMPLETE ONLY AREA THAT IS CHANGING E.G.: MARRIAGE, DIVORCE, DROPPING DEPENDENT...**
- **IF ENROLLING A DEPENDENT/STUDENT, A STUDENT CERTIFICATION FORM MUST BE INCLUDED WITH THE APPLICATION.**
- **IF YOU DO NOT WANT ANY COVERAGE OR IF YOU REJECT SOME OF THE COVERAGE OPTIONS BUT ACCEPT OTHERS, COMPLETE THE WAIVER AREA BELOW.**

### WAIVER

**A. Waived Coverages:** I do NOT want...(Check all that apply)

- HEALTH through Consumers Life Insurance Company, a Medical Mutual of Ohio® Company  
 HEALTH through Consumers Life for the following dependents only: (Remember to complete the rest of this application)  
 1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_ 4) \_\_\_\_\_ 5) \_\_\_\_\_  
 LIFE/DISABILITY through Fort Dearborn Life Insurance Co. (FDL)

**B. Current Health Coverage Status:** I have...(Check one)

- Coverage through my Spouse's Employer: \_\_\_\_\_  
Spouse's Company Name  
 No coverage  
 Other coverage: \_\_\_\_\_

**C. Authorization:** The terms of this waiver are explained below. I have read and understand these terms.

Company Name: \_\_\_\_\_  
 Print Employee Name: \_\_\_\_\_ Employee Social Security #: \_\_\_\_\_  
 Print Spouse Name: \_\_\_\_\_ Spouse Social Security #: \_\_\_\_\_  
 Signature of Employee: \_\_\_\_\_ Date: \_\_\_\_\_

### THE EXPLANATION OF WAIVER

I understand that if I check any box in Question A of the Waiver above that I am choosing not to have those persons covered under the health, life or disability insurance and any later application 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 health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 31 days after your other coverage ends. 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, provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.**

# HEALTH AND LIFE APPLICATION / POLICY CHANGE

GROUP #	SECTION
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## 1. (Please Print) ABOUT YOU AND YOUR JOB...

LAST NAME		SOCIAL SECURITY NUMBER		COMPANY NAME/EMPLOYER	
FIRST NAME	M.I.	DATE OF BIRTH	SEX (M or F)	OCCUPATION/JOB TITLE	EMPLOYEE/CLOCK#
STREET ADDRESS		HOME PHONE NUMBER ( ) -		DEPARTMENT NAME	DEPT. #
CITY	STATE	ZIP CODE	FULL TIME DATE OF (RE)HIRE / /	EMPLOYMENT STATUS <input type="checkbox"/> ACTIVE <input type="checkbox"/> RETIRED <input type="checkbox"/> COBRA	
EMAIL ADDRESS	MARITAL STATUS: <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED		BUSINESS PHONE ( ) - EXT.	COBRA EXPIRATION DATE / /	

## 2. (Please Print) WHAT YOU WANT DONE...

<p style="text-align: center;"><b>A) NEW POLICY APPLICATION</b></p> <p>1. Type of Coverage:  <u>PRIMARY COVERAGE:</u>                  Network Choice _____</p> <p><u>ADDITIONAL COVERAGE(S):</u>    <input type="checkbox"/> Dental    <input type="checkbox"/> Life                  (check all that apply)        <input type="checkbox"/> Vision</p> <p>2. Who do you want Covered?  <input type="checkbox"/> You Only    <input type="checkbox"/> You and One Other Person  <input type="checkbox"/> You and Your Family</p>	<p style="text-align: center;"><b>B) CHANGE TO AN EXISTING POLICY</b></p> <p>1. Group # _____ Section # _____</p> <p>2. Date of Change: ____/____/____</p> <p>3. Action (Check the Type of Change)</p> <p><input type="checkbox"/> ADD DEPENDENT TO POLICY (LIST DEPENDENTS IN SECTION 3 BELOW)</p> <p><input type="checkbox"/> DELETE DEPENDENT FROM POLICY (LIST DELETED DEPENDENTS IN SECTION 3 BELOW)</p> <p><input type="checkbox"/> MARRIAGE: DATE MARRIED: _____</p> <p><input type="checkbox"/> NAME CHANGE: FORMER NAME: _____</p> <p><input type="checkbox"/> NETWORK CHOICE CHANGE: _____</p> <p><input type="checkbox"/> OTHER: _____</p>
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## 3. (Please Print) ABOUT YOU AND YOUR COVERED DEPENDENTS...

A.	(A)dd (C)hange (D)elete	First Name	Last Name	Social Security #	Date of Birth	Sex M or F	Height	Weight	Relationship To You*
Self				- -	- -				
Spouse				- -	- -				
<b>1</b>				- -	- -				
<b>2</b>				- -	- -				
<b>3</b>				- -	- -				
<b>4</b>				- -	- -				
<b>5</b>				- -	- -				

\*Relationship To You: C = child, SC = stepchild, AC = adopted child, O = other\* (\*attach legal documentation)

## 4. (Please Print) ABOUT YOUR OTHER HEALTH INSURANCE AND MEDICARE...

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

What date did/will the above health insurance or health benefit program terminate?    /    /

**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
			/ /	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Hospital Only <input type="checkbox"/> Vision <input type="checkbox"/> Prescription Drug	<input type="checkbox"/> Active <input type="checkbox"/> Retired	<input type="checkbox"/> Single <input type="checkbox"/> Family

**MEDICARE INFORMATION:**

Are you covered by Medicare?     YES     NO    If YES, Medicare No. \_\_\_\_\_    EFFECTIVE DATE: PART A: / /    PART B: / /     Hemodialysis

Is your spouse or dependent covered by Medicare?     YES     NO    If YES, Medicare No. \_\_\_\_\_    EFFECTIVE DATE: PART A: / /    PART B: / /     Hemodialysis

## 5. (Please Print) ABOUT YOUR LIFE AND DISABILITY INSURANCE...

**IF YOUR EMPLOYER OFFERS ANY OF THE FOLLOWING COVERAGES, PLEASE INDICATE IF YOU WOULD LIKE TO ENROLL IN ANY OF THESE COVERAGES.**

BASIC LIFE <input type="checkbox"/> YES <input type="checkbox"/> NO	DEPENDENT LIFE <input type="checkbox"/> YES <input type="checkbox"/> NO	SHORT TERM DISABILITY <input type="checkbox"/> YES <input type="checkbox"/> NO	If you elect life insurance, you must name a beneficiary in the space below. Unless otherwise noted, if two primary beneficiaries are named, the proceeds will be paid in equal shares to the primary beneficiaries surviving you. Total benefit split must equal 100%.
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**IF ANY YES BOX IS CHECKED ABOVE, COMPLETE THE REMAINDER OF THIS SECTION.**

GROUP/DIVISION NUMBER:	CLASS:	SALARY \$	<input type="checkbox"/> WEEKLY <input type="checkbox"/> MONTHLY <input type="checkbox"/> ANNUAL	<b>FOR FDL USE ONLY</b> EFFECTIVE DATE: ____/____/____
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Beneficiary Last Name	Beneficiary First Name	Beneficiary Social Security #	Date of Birth	Relationship	Benefit Split
PRIMARY					%
PRIMARY					%
SECONDARY					%

## MEDICAL HISTORY QUESTIONNAIRE

### For groups with 20 or more eligible employees

6A. In the section below please provide the details of any medical condition for which you or your dependents have received treatment within the past five years. Conditions include, but are not limited to, AIDS or AIDS-Related Complex; alcohol or drug dependency, arthritis, cancer, diabetes (include 3 recent blood sugar readings), diseases of the heart (including hypertension), lung, kidney or blood, mental health disorder, muscle or nervous system disorder, spinal disc disease, transplant, autoimmune disorder, infertility or any other medical condition not listed.

Name of Individual	Condition, Illness or Injury	Dates of Treatment From/To	Treatment Details/Current Status* reading

6B. In the section below please provide the details for any medical condition, within the past 5 years, for which you, your spouse or any listed dependent have been treated, diagnosed as having, or thought you should seek medical advice that is not listed above.

Name of Individual	Condition, Illness or Injury	Dates of Treatment From/To	Treatment Details/Current Status*

6C. Are you, your spouse, or any dependent(s) currently taking any prescriptions or over the counter medications?

Yes    No   If yes, please list all medications with conditions.

Name of Individual	Medication(s)	Frequency/Dosage	Condition Being Treated*

6D. Are you, your spouse, or any dependent currently pregnant or an expectant parent?    Yes    No

If yes, please provide: Name: \_\_\_\_\_, Relationship \_\_\_\_\_, Due Date: \_\_\_\_\_

\*If additional space is required to respond, please attach additional sheet to this questionnaire.

**I hereby apply to Consumers Life Insurance Company and/or Fort Dearborn Life Insurance Co. (FDL) for the coverage indicated on this application.**

- \* **I authorize:** (1) payroll deduction(s) and remittance of any required contribution for coverage to Consumers Life and/or FDL or any Administrator assigned by Consumers Life or FDL (2) release of information, without limitation, from any medical/medically-related facility, government agency or person: (a) to evaluate this application for up to 30 months old from the date of this application; (b) to adjudicate claims submitted on behalf of me or my dependents as long as I am covered under this policy; (c) for utilization review programs to monitor health services or quality improvement activities; (d) for credentialing purposes. I authorize the applicable carrier to provide a photocopy of this release to any physician or medical institution to obtain records for the purposes stated above.
- \* **I understand:** (1) any untrue or incomplete information, statements or answers on this application (whether intentional or not), can result in denial of a claim or rescission of coverage and may subject me to legal action by Consumers Life or FDL; (2) to be eligible for health, life or disability coverage, I must be a full-time employee, as defined by my employer; (3) I must be actively at work as defined in the group policy to obtain life and/or disability income coverage. If I am not actively at work on the date my life and/or disability income coverage would become effective, my coverage will not begin until the day I return to work; (4) if coverage is issued, it will be based on full reliance on the information contained in this application.
- **I understand and agree that no agent or broker has the authority:** (1) to bind Consumers Life and/or FDL by making promises regarding eligibility, benefits, or the issuance of a policy; (2) to waive any answer or any portion of any answer to any question on this application or any information Consumers Life and/or FDL requests; (3) approve coverage; (4) make or alter any contract on behalf of Consumers Life and/or FDL; or (5) waive or alter any of Consumers Life Insurance Company's and/or FDL's other rights or requirements. All contract terms must be in writing and signed or accepted in writing by an authorized representative of Consumers Life and/or FDL to be binding on Consumers Life and/or FDL.

**8. SIGNATURES - Sign after completing and reading all applicable sections (including front of this application).**

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. Signature of Spouse authorizes release of information.

\_\_\_\_\_  
Your Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Your Spouse's Signature  
(if applying for dependent coverage)

\_\_\_\_\_  
Date

**WARNINGS:** Any person who, with intent to defraud or knowing that he or she 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.

If you or your family members are covered by more than one health care 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.