Employee Enrollment/Change Form For Individuals in Groups with 1-99 Eligible Employees

Section I: 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 coverage designated.

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

Myself: ☐ Medical
Spouse or Domestic Partner: ☐ Medical
Child(ren): ☐ Medical

Please list name(s) of spouse 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 carrier's group plan offered by this employer

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 _____ MMO 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.

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	860144

BEX Benefit Plan
The Future of Health Benefits

Section II: ACTION REQUIRED

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

Select Coverage: (Check all that apply)

☐ Health/Drug Product Name: _____

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

Relationship	First Name, MI (and last name, if different)	Social Security Number[2]	Birth Date	Gender	Smoker	Height	Weight
Self				☑ M ☐ F	☐ Y ☐ N		
Spouse				☑ M ☐ F	☐ Y ☐ N		
Domestic Partner[1]				☐ M ☐ F	☐ Y ☐ N		
Dependent Child[2]				☑ M ☐ F	☐ Y ☐ N		
Dependent Child[2]				☑ M ☐ F	☐ Y ☐ N		
Dependent Child[2]				☐ M ☐ F	☐ Y ☐ N		

[1]Refer to Section VIII, Number 11, Terms and Conditions, for domestic partner eligibility requirements.

[2]Providing Social Security Number will maximize claims accuracy and expedite processing.

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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 Disease ☐ Disability, Indicate Reason: _____
				☐ Age ☐ End Stage Renal Disease ☐ 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 this plan will be the secondary payer to Medicare Part B, this plan 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.

(If you are entitled to Medicare because you are 65 and over and your employer employs fewer than 20 employees; or if you are entitled to Medicare due to disability and your employer employs fewer than 100 employees, Medicare will be the primary payer, that is, Medicare must pay benefits before the group health plan pays benefits.) Special rules apply when coverage is offered by a multi-employer plan such as this one. If you have questions about which coverage is primary, contact the Builders Exchange Benefit Plan.

Continuing Coverage (other than Medicare) Are you or any dependent keeping other 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:_____

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BEX Benefit Plan

Section VI: MEDICAL HEALTH QUESTIONNAIRE

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 _____

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

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Section VII: TERMS AND CONDITIONS

1. I hereby apply to the Builders Exchange Benefit Plan. I acknowledge that I am applying for an employee health benefit offered collectively through the Builders Exchange Benefit Plan 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 Builders Exchange Benefit Plan Summary Plan Description and Plan Document as amended from time to time by the Board of Trustees of the Builders Exchange Benefit Plan.

2. I authorize (1) payroll deduction(s) and remittance of any required contribution for coverage to the Builders Exchange Benefit Plan 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 Builders Exchange Benefit Plan 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 Builders Exchange Benefit 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.

3. 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 have answered every application question set forth in this application; (c) all of my answers to each of the questions are accurate, complete and true; and (d) I did not sign a blank or partially completed Application.

4. I understand and agree that I am solely and exclusively responsible for the truth, accuracy and completeness of all of the answers contained in this Application. 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 Builders Exchange Benefit Plan 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 Health benefits that are inconsistent with, or different from, any written information provided by the Builders Exchange Benefit Plan; (d) to bind the Builders Exchange Benefit Plan 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 Plan. All contract terms must be in writing and signed or accepted in writing by an authorized representative of the Builders Exchange Benefit Plan 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.

5. 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 Builders Exchange Benefit Plan has 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.

6. 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 in this Application can result in rescission of coverage and may subject me to legal action by the Builders Exchange Benefit Plan.

7. To be eligible for coverage, I must be an active full employee as defined by the group participation agreement.

8. I understand that in order to be eligible for coverage through the Builders Exchange Benefit Plan, I must meet the eligibility requirements set forth in the plan documents of the Builders Exchange Benefit Plan and: 1) for coverage as an employee, I must be an active, full-time employee drawing a regular paycheck; to be eligible for coverage, I must be an active full employee as defined by the group participation agreement.

Continued on page 6

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Section VII: TERMS AND CONDITIONS (continued)

9. My dependents and I understand and agree that any information obtained will not be released by the Builders Exchange Benefit Plan 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 Builders Exchange Benefit Plan Board of Trustees at: Builders Exchange Benefit Plan, 9555 Rockside Rd., Cleveland, OH 44125. 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 Builders Exchange Benefit Plan Board of Trustees.

10. 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.

11. 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.

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 Builders Exchange Benefit Plan.

_____ _____

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).

Multi-Language Interpreter Services & Nondiscrimination Notice

ATTENTION: If you speak <insert language>, language assistance services, free of charge, are available to you. Call 1-800-382-5729 (TTY: 711).

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 1-800-283-008-9275 رقم هاتف الصم والبكم: 117).

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).

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).

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, you can contact:

Paul Mancino, Vice President, Assistant General Counsel & Deputy Compliance Officer
Medical Mutual of Ohio
2060 East Ninth Street
Cleveland, OH 44115-1355

Phone: (216) 687-2675
Fax: (216) 687-2623
Email: Paul.Mancino@MedMutual.com

You can file a grievance in person or by mail, fax or email. 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:
  (800) 368-1019 (TDD: (800) 537-7697)
- Complaint forms are available at:
  hhs.gov/ocr/office/file/index.html

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