

Dentist's Choice Health Care Alliance APPLICATION AND POLICY CHANGE

(PLEASE USE BALL POINT PEN)

ENROLLEE: <input type="checkbox"/> POLICY CHANGE		<input type="checkbox"/> NEW ENROLLEE													
GROUP NO.: _____		LEVEL OF BENEFITS: <input type="checkbox"/> Single <input type="checkbox"/> Two Persons <input type="checkbox"/> Family <input type="checkbox"/> Medicare Supplemental													
		EMPLOYMENT STATUS: <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> COBRA													
EMPLOYEE CLOCK NUMBER: _____		EMPLOYEE DEPT. NO.: _____													
		PAYROLL LOCATION: _____													
CHANGES: <input type="checkbox"/> Add Dependents due to: <input type="checkbox"/> Marriage <input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Drop Dependents Due To: <input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> Other _____		<input type="checkbox"/> New Name <input type="checkbox"/> New Address <input type="checkbox"/> Change to Medicare Elig. <input type="checkbox"/> Change Coverage													
		<input type="checkbox"/> Other _____													
		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2" style="text-align: center;">DATE OF EVENT</td> <td colspan="2" style="text-align: center;">COV. OR CHANGE EFF. DATE</td> </tr> <tr> <td style="text-align: center;">MO.</td> <td style="text-align: center;">DAY</td> <td style="text-align: center;">MO.</td> <td style="text-align: center;">DAY</td> </tr> <tr> <td style="text-align: center;">YR.</td> <td style="text-align: center;">YR.</td> <td style="text-align: center;">YR.</td> <td style="text-align: center;">YR.</td> </tr> </table>		DATE OF EVENT		COV. OR CHANGE EFF. DATE		MO.	DAY	MO.	DAY	YR.	YR.	YR.	YR.
DATE OF EVENT		COV. OR CHANGE EFF. DATE													
MO.	DAY	MO.	DAY												
YR.	YR.	YR.	YR.												
Last Name		First Name													
		M Initial													
Street Address		City													
		State													
		Zip													
		Phone No.													
Employee Date of Birth MO. DAY YR.		Sex <input type="checkbox"/> M <input type="checkbox"/> F													
Employee Social Security Number		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced													
Date Married MO. DAY YR.		Date of Hire-Full Time MO. DAY YR.													
Employer Company Name		Job Title													
Check Coverage Desired: <input type="checkbox"/> Health <input type="checkbox"/> Drug <input type="checkbox"/> Dental <input type="checkbox"/> Vision															
MEDICARE INFORMATION															
Are you covered by Medicare? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, Medicare No. _____ Effective Date: _____ <input type="checkbox"/> Hemodialysis															
Is your spouse covered by Medicare? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, Medicare No. _____ Effective Date: _____ <input type="checkbox"/> Hemodialysis															
OTHER INSURANCE INFORMATION															
DO YOU OR ANY OF YOUR DEPENDENTS HAVE ANY OTHER HEALTH OR DENTAL COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, COMPLETE THIS SECTION BELOW.															
NAME OF POLICY HOLDER		NAME AND ADDRESS OF OTHER INSURANCE COMPANY													
POLICY NUMBER		EFFECTIVE DATE													
		/ /													
COVERAGE TYPES		WORK STATUS													
<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													
POLICY TYPE															
What date did your most recent health insurance program become effective (check box if no prior/current coverage)? _____/_____/_____ <input type="checkbox"/> No coverage															
What date did/will this health insurance program terminate (check box if no prior/current coverage)? _____/_____/_____															
DEPENDENT INFORMATION															
RELATIONSHIP	BIRTH DATE	SEX	LAST NAME (ONLY IF DIFFERENT)												
Spouse	MO. DAY YR.														
<input type="checkbox"/> Child <input type="checkbox"/> Adopted <input type="checkbox"/> Stepchild <input type="checkbox"/> Other		<input type="checkbox"/> M <input type="checkbox"/> F													
<input type="checkbox"/> Full-Time Student <input type="checkbox"/> Disabled Medicare Elig.; <input type="checkbox"/> Hemodialysis <input type="checkbox"/> Disability															
<input type="checkbox"/> Child <input type="checkbox"/> Adopted <input type="checkbox"/> Stepchild <input type="checkbox"/> Other		<input type="checkbox"/> M <input type="checkbox"/> F													
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<input type="checkbox"/> Full-Time Student <input type="checkbox"/> Disabled Medicare Elig.; <input type="checkbox"/> Hemodialysis <input type="checkbox"/> Disability															
1. Legal Documentation (court decree, guardianship papers, etc.) must be attached to this application if relationship is marked other.															
SIGNATURE															
I hereby apply to Medical Mutual (MM) for the coverage indicated above. I authorize my employer/organization to deduct from my pay and remit any required contribution for the cost of said coverage. I authorize any medical professional, hospital, clinic, or other medical or medically related facility, government agency, or other person to provide to MM information including copies of records concerning advice, care or treatment provided to me and/or my dependents including, without limitation, information relating to mental illness or use of drugs or alcohol. I understand that the kind of coverage for which I am making application contains coordination of benefits, workers' compensation, and subrogation provisions and acknowledge MM's right to enforce these provisions. I have read the above statements and represent that the information provided is true and complete to the best of my knowledge. I understand that the provision of any false information on this application may result in the termination of my benefits and may subject me to legal action by MM. I understand I must notify MM within 30 days of occurrence of any changes in status. I understand that if I am not actively at work on the date my coverage would otherwise become effective, my insurance will not begin until the day I return to work.															
Applicant's Signature _____ Date: _____															
WAIVER															
I hereby waive coverage under the health insurance program <input type="checkbox"/> FOR MYSELF <input type="checkbox"/> FOR MYSELF AND FAMILY MEMBERS <input type="checkbox"/> FOR FAMILY MEMBERS ONLY <input type="checkbox"/> FOR ONLY THE FOLLOWING: _____															
I understand that if I decide to enroll or add family members at a later date, I will be required to complete a medical history questionnaire and meet certain medical underwriting requirements before coverage will be offered. I further understand that if I and/or my eligible family members are accepted for enrollment at some future date, I am subject to the pre-existing condition restrictions specified in the contract.															
Signature _____ 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)

Dentist's Choice Health Care Alliance
MEDICAL MUTUAL OF OHIO™
Medical History Questionnaire

APPLICANT				DATE OF BIRTH	SEX	HEIGHT	WEIGHT
LAST	MAIDEN NAME (If applicable)	FIRST	MIDDLE INITIAL		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		

SOCIAL SECURITY NUMBER	APPLICANT'S EMPLOYER	OCCUPATION	GROUP NUMBER IF ASSIGNED

MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> SEPARATED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	Are Dependents (Spouse and Children) to be covered YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, complete the following:			
	DEPENDENTS (FULL NAME)	DATE OF BIRTH	HEIGHT	WEIGHT

1. Have YOU or any of your listed DEPENDENTS been diagnosed in the past or are currently being treated by a physician for any of the following conditions?

CONDITIONS	YES	NO	CONDITIONS	YES	NO	CONDITIONS	YES	NO
1. A.I.D.S./A.R.C.			19. OTHER LUNG DISORDERS			35. HEART ATTACK/M.I.		
2. ARTHRITIS			20. LIVER DISORDERS			36. CORONARY ARTERY DISEASE		
3. RHEUMATOID ARTHRITIS			21. CONGENITAL DISEASE/DEFECT			37. BYPASS SURGERY		
4. OSTEO ARTHRITIS			22. PARALYSIS			38. CONGESTIVE HEART FAILURE		
5. BACK/SPINAL DISORDERS			23. MULTIPLE SCLEROSIS			39. PACEMAKER		
6. BACK STRAIN/SPRAIN			24. CEREBRAL PALSY			40. ISCHEMIC HEART DISEASE		
7. SCOLIOSIS			25. EPILEPSY			41. OTHER HEART DISORDERS		
8. SPINA BIFIDA			26. PARKINSON'S			42. HIGH BLOOD PRESSURE		
9. ULCERATIVE COLITIS			27. ALZHEIMER'S DISEASE			IF YES, GIVE LAST 3 PRESSURES & DATES		
10. DIVERTICULITIS			28. OTHER NEUROLOGICAL DISORDERS			A.	B.	C.
11. CHROHN'S DISEASE			29. HEMOPHILIA			44. ALCOHOL OR DRUG DEPENDENCY		
12. GASTRIC/PEPTIC ULCER			30. KIDNEY/URINARY DISORDERS			45. ATTEMPTED SUICIDE		
13. OTHER BOWEL/STOMACH DISORDERS			31. TUMORS/GROWTHS			46. ANOREXIA/BULIMIA		
14. STROKE (DATE)			32. JUVENILE DIABETES			47. CHRONIC DEPRESSION		
15. CANCER, LEUKEMIA OR MELANOMA			33. DIABETES MELLITUS			48. OTHER MENTAL/EMOTIONAL DISORDERS		
16. EMPHYSEMA			34. YES, GIVE LAST 3 BLOOD SUGARS & DATES			49. VENEREAL DISEASE		
17. CHRONIC BRONCHITIS			A.	B.	C.	50. DEAFNESS		
18. ASTHMA								

2. If any of the conditions are checked "YES" please explain below, (use additional paper if necessary). Please indicate specific location of condition (example: right knee), details of injury, ailment or condition.

PATIENT'S NAME	CONDI-TION NUMBER	DIAGNOSIS AND TYPE OF TREATMENT	HOSPI-TALIZED	ATTENDING PHYSICIAN	DATE(S) OF TREATMENT(S)
			<input type="checkbox"/> YES <input type="checkbox"/> NO	Name Address	From To
			<input type="checkbox"/> YES <input type="checkbox"/> NO	Name Address	From To

3. Have YOU or any of your listed DEPENDENTS consulted a physician during the past five years for any conditions not listed in question #1? (Do not include physicals with normal results.)

PERSON	MEDICAL CONDITION	TREATMENT/MEDICATION	DATE TREATED OR CONSULTED WITH DOCTOR	DECREE OF RECOVERY
			FROM TO	

4. Do **YOU** or any of your listed **DEPENDENTS** currently take prescribed medications (including fertility drugs)?
 YES_____ NO_____. If yes, explain below.

NAME OF PERSON	MEDICATION/AMOUNTS PER DAY	FOR WHAT CONDITION

5. Have **YOU** or any listed **DEPENDENT** ever had abnormal results on any of the following: Blood Count, Blood Test, Wasserman, Urinalysis, EKG, X-Ray, Ultrasound or Amniocentesis?
 YES_____ NO_____. If yes, please explain._____

6. Are **YOU** or any **DEPENDENTS** listed herein now pregnant? YES_____ NO_____. If yes, due date._____
 Is this pregnancy high risk or expected to have complications? YES_____ NO_____.
 If yes, please explain _____

7. Has future surgery, diagnostic testing or medical treatment been recommended for any person listed on this application?
 YES_____ NO_____. If yes, please explain. Give name, date, ailment and the type of operation, test or treatment recommended._____

8. Have **YOU** or any **DEPENDENT** listed been treated on an outpatient basis; Testing, Rehabilitation, Home Health Care or Emergency Room within the last two years? YES_____ NO_____. If yes, please explain._____

9. Has any insurance company refused or restricted any health coverage on any person listed above within the last five years?
 YES_____ NO_____. If yes, please explain._____

10. List **ANYONE** on this application under age 65 who is covered by Medicare: _____

11. Do **YOU** or any listed **DEPENDENT** have a condition covered by Workers Compensation?
 YES_____ NO_____. If yes, please list condition and the Workers Compensation number._____

TO BE SIGNED BY APPLICANT (AND SPOUSE IF DEPENDENT COVERAGE IS APPLIED FOR)

I have read this entire application and I declare all information, statements and answers herein to be true and complete. I also understand and agree with Medical Mutual of Ohio™ that coverage, if issued, will be issued in full reliance on this application and that any untrue or incomplete information, statements or answers, whether intentional or not, in this application can result in denial of a claim, or rescision of coverage, and Medical Mutual of Ohio™ may present a photocopy of this section of application to any physician or medical institution and is authorized to request and receive all records or information of medical examination, history and treatment for any applicant. I also will be responsible for any cost incurred by Medical Mutual of Ohio™ to receive medical information needed to make a decision for coverage.

_____ X
 Date Applicant's Signature

_____ X
 Date Spouse's Signature

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Please Complete The Following:

I. Dental Practice Name (if different than dentist's name)

Dentist's Name(s): _____ Component Society: _____

Dentist's SSN or ADA Number (Required): _____

Dentist Signature Required to Process Application: _____

If Dentist Participates in Automatic Payment Plan, do you want new employee to be added?

Yes No

II. Employee Name: _____

Office Address: _____

Street _____ City _____ Zip _____ County _____

Business Phone _____ Business Fax _____

* Hours Worked (min 25 hrs a wk) _____ Occupation _____

III.

Please Confirm Which Benefits Plan(s) You Are Interested In Applying For:

Traditional Gold:	\$250/\$500	\$500/\$1000		
Classic:	\$250/\$500	\$500/\$1000		
SuperMed Plus:	\$250/\$500	\$500/\$1000	\$750/\$1500	\$1000/\$2000
SuperMed Plus:	\$2000/\$4000 (HSA)	\$3000/\$6000 (HSA)		

Please Note:

1. Member Dentist need to be enrolled for a minimum of 5 (Five) years as a fulltime-active participant of DCHCA healthcare program before qualifying for the DCHCA Medicare Supplement Program (**MEDIFIL**).
2. (The new enrollment cut-off is the 24th of the month prior to start date)

EFFECTIVE DATE REQUESTED: _____