Employee Name	Group #
Social Security #	Section # (required)

100+ Employee Application & Change Form

Carolina Care Plan® A Medical Mutual of Ohio Company

Consumers Life Insurance Company® A Medical Mutual of Ohio Company

The Lincoln National Life Insurance Company

1. ACTION REQUESTED

☐ **New Policy Application** or ☐ **Rehire**

Requested Effective Date: _____ (Optional)

Select Coverage: (Check all that apply)

- ☐ HMO Product Name: _____
- ☐ POS Product Name: _____
- ☐ HDHP Product Name: _____
- ☐ Vital Access Product Name: _____
- ☐ Life Complete Life and Disability Benefit section
- ☐ Other _____

☐ **Policy Change**

Requested Date of Change: _____ (Optional)

Action: (Check the type of change)

- ☐ Address change (Enter new address in Section 2)
- ☐ Add dependent to policy (List dependent(s) in Section 3)
- ☐ Delete dependent from policy (List dependent(s) in Section 3)
- ☐ Add spouse due to marriage. Date Married: _____ (List spouse in Section 3)
- ☐ Name change. Former Name: _____
- ☐ Cancel coverage
- ☐ Other _____

2. EMPLOYEE INFORMATION

Last Name	First Name	MI	Social Security#	Date of Birth (MM/DD/YYYY)	Gender ☐ M ☐ F

Employment Status ☐ Active ☐ Retired ☐ COBRA

Marital Status ☐ Single ☐ Married, Date Married: _____ ☐ Divorced ☐ Separated ☐ Widowed

Employer or Group Name	Date of Hire (MM/DD/YYYY)	Job Title	
Home Address	**City**	**State**	**Zip Code**
Email Address		**Home Phone Number**	

3. COVERED DEPENDENTS

Relationship	First Name	Last Name (if different)	Social Security #	Date of Birth	Gender
Spouse					☐ M ☐ F
☐ Child[1] ☐ Adopted[2] ☐ Stepchild[1] ☐ Other[2]					☐ M ☐ F
☐ Child[1] ☐ Adopted[2] ☐ Stepchild[1] ☐ Other[2]					☐ M ☐ F
☐ Child[1] ☐ Adopted[2] ☐ Stepchild[1] ☐ Other[2]					☐ M ☐ F
☐ Child[1] ☐ Adopted[2] ☐ Stepchild[1] ☐ Other[2]					☐ M ☐ F

[1] If over limiting age, Student or Disability Certification form must be attached to this application

[2] Legal Documentation (court decree, guardianship papers, etc.) must be attached to this application

4. 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 ☐ Disability, Indicate Reason: _____
				☐ Age ☐ End Stage Renal ☐ Disability, Indicate Reason: _____

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

Prior or Ending Coverage **Do you or any dependent have any prior or ending health insurance? ☐ Yes ☐ No If yes, please complete the section below:**

- What date did your most recent health insurance become effective? _____ • What date did/will this health insurance terminate? _____
- Please indicate the carrier name for the above health insurance: _____

5. PRE-EXISTING CONDITION NOTICE

The following information is attached to and incorporated into your application to Carolina Care Plan, Inc.:

This plan imposes a pre-existing condition exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within no more than a six-month "look-back" period. Generally, this look-back period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the look-back period ends on the day before the waiting period begins. The pre-existing condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 30 days after birth, adoption, or placement for adoption. This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the maximum 12-month (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you having creditable coverage. Please contact us if you need help demonstrating creditable coverage. All questions about the pre-existing condition exclusion and creditable coverage should be directed to your agent or Customer Service at 1-800-232-2821.

The following information applies to the disability coverage being applied for through Consumers Life Insurance Company

If disability coverage is approved, and a pre-existing condition limitation or exclusion applies to your coverage, refer to your Certificate for specific information on the limitation or exclusion.

Employee Name	Group #
Social Security #	Section # (required)

CAROLINA CARE PLAN®
A MEDICAL MUTUAL OF OHIO COMPANY

CONSUMERS LIFE INSURANCE COMPANY®
A MEDICAL MUTUAL OF OHIO COMPANY

The Lincoln National Life Insurance Company

6. LIFE AND DISABILITY BENEFITS

A. COVERAGE SELECTION

Your group insurance program provided by Consumers Life Insurance Company may not include all the benefits listed below. Ask your employer for the details about the benefits available to you, your cost, if any, and whether you will be required to submit evidence of insurability.

Y	N	Basic Coverage(s)	Add/Delete	Total Amount of Coverage Applied
☐	☐	Basic Life		
☐	☐	Basic AD&D		
☐	☐	Dependent Life		
☐	☐	Short Term Disability		
☐	☐	Long Term Disability		
☐	☐	Supplemental Life		
☐	☐	Supplemental AD&D		

B. CLASS AND SALARY INFORMATION

Class:	Earnings: $ _____ ☐ Weekly ☐ Monthy ☐ Annual	Occupation/Job Title:

C. BENEFICIARY DESIGNATION

(For Employee Only: Must be completed if you have applied for Life or AD&D insurance). If two or more primary beneficiaries are named, and you do not list benefit percentages, proceeds will be paid in equal shares to the named primary beneficiaries who survive you. If no primary beneficiary survives you, proceeds will be paid to the contingent beneficiary(ies). If you list benefit percentages, the total must equal 100%. (Employee is the beneficiary of proceeds from spouse or child coverage.)

Last Name	First Name	Date of Birth	Relationship	Benefit %
Primary:				
Primary:				
Contingent:				
Contingent:				

7. TERMS AND CONDITIONS

I hereby apply to the carrier(s) offering the coverage indicated on this application. Carolina Care Plan, Inc.(CCP) is offering the health coverage; Consumers Life Insurance Company (CLIC) is offering Life, AD&D, and disability coverage; and Lincoln National Life Insurance Company (LNL) is offering dental coverage.

I authorize: (1) payroll deduction(s) and remittance of any required contribution for coverage to CCP, CLIC, LNL and/or any affiliates or divisions of these carriers; (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 CCP, CLIC, LNL and/or any affiliates or division of these carriers: (a) to evaluate this Application; (b) to adjudicate claims submitted on behalf of me or my dependents as long as I am covered under the policy; (c) for utilization review programs to monitor health services or quality improvement activities and/or; (d) for credentialing purposes. I authorize CCP, CLIC, and/or LNL 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 released by CCP, CLIC, or LNL 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 (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 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. To revoke this authorization, I must do so in writing and send my written revocation to the respective carrier's Privacy Office. 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 respective carrier's Private Office.

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.

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 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 authorized release of information described in this application.

Employee Signature	Date	Your Spouse's Signature (if applying for coverage)	Date

WARNING: Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against any insurer, submits any application or files a claim containing a false or deceptive statement is guilty of insurance fraud.