Health Benefits Plan
OHIO STATE MEDICAL ASSOCIATION

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, life or disability coverage designated.

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

Myself:	☐ Medical	☐ Dental	☐ Vision	☐ Life/Disability
Spouse or Domestic Partner:	☐ Medical	☐ Dental	☐ Vision	☐ Life/Disability
Child(ren):	☐ Medical	☐ Dental	☐ Vision	☐ Life/Disability

Please list name(s) of spouse/domestic partner 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.

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

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Section II: ACTION REQUIRED

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

Select Coverage: (Check all that apply)

- ☐ Health/Drug Product Name: ___________________
- ☐ Dental* Product Name: ___________________
- ☐ Vision* Product Name: ___________________

*Dental and vision benefits are insured through Medical Mutual of Ohio.

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.

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

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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 OSMA Insurance Agency.

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:____

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

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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*	☑ ☐
				☐ ☐
				☐ ☐
				☐ ☐
				☐ ☐
				☐ ☐

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

Section VII: PRODUCTS

Life and Disability Benefits – These benefits are underwritten and insured by Consumers Life Insurance Company.

A. COVERAGE SELECTION

Your group insurance 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.

Employer Paid Plans*

Elect	Waive	Coverage Type
☐	☐	Basic Life and AD&D
☐	☐	Dependent Life
☐	☐	Short-Term Disability
☐	☐	Long-Term Disability

Class and Salary Information

Life Class:
Occupation/Job Title:
Current Earnings: $ ☐ Hour ☐ Month ☐ Week ☐ Year

*If employer pays 100% of premium, employee may not waive coverage

Employee Paid Plans**

Elect	Waive	Coverage Type	Amount
☐	☐	**Participation Free Voluntary Life and AD&D**-portable coverage (can be chosen in increments of $10,000, to a maximum of $50,000)	$ ______________
☐	☐	**Participation Free Voluntary Short-Term Disability** (can be choosen in increments of $50, minimum of $100, to a maximum of $750, not to exceed 66⅔% of employee's Basic Weekly Wage)	$ ______________
☐	☐	**Supplemental Life**	$ ______________
☐	☐	**Supplemental AD&D**	$ ______________
☐	☐	**Dependent Life**	$ ______________

If your group insurance program offers participation free voluntary life and AD&D, each employee electing will need to complete **Section D: Participation Free Eligibility Questions

Employees must elect Participation Free Voluntary Life and AD&D to be eligible for Participation Free Voluntary Short-Term Disability coverage.

B. VOLUNTARY SHORT-TERM DISABILITY PRE-EXISTING CONDITION NOTICE

Consumers Life will not cover a disability which begins in the first 12-months after your effective date of coverage that is caused by, contributed to by, or results from a Pre-existing condition.

A Pre-existing condition is a sickness or injury for which you, within 12 months of your effective date of coverage:

1. Received medical treatment, consultation, care of service, including diagnostic measures, or
2. had taken prescribed drugs or medicines.

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:				

Continued on page 6

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

Section VII: PRODUCTS (continued)

Life and Disability Benefits (continued)

D. PARTICIPATION FREE ELIGIBILITY QUESTIONS:

If electing Participation Free Voluntary Life and AD&D, please answer questions 1-5 below:

1.) Have you ever been diagnosed with, treated for, prescribed medication for heart disease, coronary artery disease, stroke, diabetes, kidney disease, liver disease, or any form of cancer other than basal cell carcinoma? ☐ Yes ☐ No

2.) Have you ever been diagnosed with AIDS, ARC or HIV (tested positive to antibodies for the HIV virus)? ☐ Yes ☐ No

3.) Have you ever been diagnosed with Lou Gehrig's Disease (ALS), Downs Syndrome, Multiple Sclerosis, Spina Bifida, Parkinson's disease, Muscular Dystrophy or Cerebral Palsy? ☐ Yes ☐ No

4.) In the past two years, have you been denied life insurance by this or any other insurance company? ☐ Yes ☐ No

5.) Does your weight, based upon your height, fall outside of an acceptable range in the following chart? ☐ Yes ☐ No

Height	Acceptable Weight Range	Height	Acceptable Weight Range
4' 5" but less than 4'6"	72 lbs to 154 lbs	5' 9" but less than 5'10"	125 lbs to 249 lbs
4' 6" but less than 4'7"	75 lbs to 156 lbs	5' 10" but less than 5'11"	129 lbs to 257 lbs
4' 7" but less than 4'8"	79 lbs to 159 lbs	5' 11" but less than 6'0"	132 lbs to 265 lbs
4' 8" but less than 4'9"	82 lbs to 161 lbs	6' 0" but less than 6'1"	136 lbs to 272 lbs
4' 9" but less than 4'10"	85 lbs to 167 lbs	6' 1" but less than 6'2"	140 lbs to 280 lbs
4' 10" but less than 4'11"	88 lbs to 173 lbs	6' 2" but less than 6'3"	144 lbs to 288 lbs
4' 11" but less than 5'0"	91 lbs to 180 lbs	6' 3" but less than 6'4"	148 lbs to 296 lbs
5' 0" but less than 5'1"	95 lbs to 186 lbs	6' 4" but less than 6'5"	152 lbs to 305 lbs
5' 1" but less than 5'2"	98 lbs to 193 lbs	6' 5" but less than 6'6"	156 lbs to 313 lbs
5' 2" but less than 5'3"	101 lbs to 199 lbs	6' 6" but less than 6'7"	160 lbs to 321 lbs
5' 3" but less than 5'4"	104 lbs to 206 lbs	6' 7" but less than 6'8"	164 lbs to 330 lbs
5' 4" but less than 5'5"	108 lbs to 213 lbs	6' 8" but less than 6'9"	168 lbs to 339 lbs
5' 5" but less than 5'6"	111 lbs to 220 lbs	6' 9" but less than 6'10"	172 lbs to 347 lbs
5' 6" but less than 5'7"	114 lbs to 227 lbs	6' 10" but less than 6'11"	177 lbs to 356 lbs
5' 7" but less than 5'8"	118 lbs to 235 lbs	6' 11" but less than 7'0"	181 lbs to 365 lbs
5' 8" but less than 5'9"	121 lbs to 242 lbs	7' 0" but less than 7'1"	184 lbs to 369 lbs

If you have answered "NO" to all of the questions above, you are eligible for participation free voluntary life and AD&D coverage, subject to the terms and conditions of the policy.

If you have answered "YES" to any of the questions above, you are not eligible for participation free voluntary life and AD&D coverage.

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

Health Benefits Plan
OHIO STATE MEDICAL ASSOCIATION

Section VIII: TERMS AND CONDITIONS

1. I hereby apply to the Ohio State Medical Association Health Benefits Plan. I acknowledge that I am applying for an employee health benefit offered collectively through the Ohio State Medical Association Health Benefits 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 Ohio State Medical Association Health Benefits Plan Summary Plan Description and Plan Document as amended from time to time by the Board of Trustees of the Ohio State Medical Association Health Benefits Plan.

2. I understand that the dental and vision benefits made available through the Ohio State Medical Association Health Benefits Plan are fully insured by Medical Mutual of Ohio ("Medical Mutual"). I understand that the life, AD&D and disability benefits made available through the Ohio State Medical Association Health Benefits Plan are fully insured by Consumers Life Insurance Company ("CLIC").

3. I authorize (1) payroll deduction(s) and remittance of any required contribution for coverage to the Ohio State Medical Association Health Benefits 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 Ohio State Medical Association Health Benefits Plan and Medical Mutual/CLIC and/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 Ohio State Medical Association Health Benefits Plan and/or Medical Mutual/CLIC 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.

4. 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.

5. 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 Ohio State Medical Association Health Benefit Plan and/or Medical Mutual/CLIC 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 Ohio State Medical Association Health Benefits Plan; (d) to bind the Ohio State Medical Association Health Benefits 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 Ohio State Medical Association Health Benefits 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.

6. 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 Ohio State Medical Association Health Benefits Plan and/or Medical Mutual/CLIC 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.

7. I agree that any untrue or incomplete information, statement or answers on this Application (whether or not intentional), can result in denial of a claim or rescission of coverage and may subject me to legal action by the Ohio State Medical Association Benefits Plan and/or Medical Mutual/CLIC.

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

Health Benefits Plan
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Section VIII: TERMS AND CONDITIONS (continued)

8. I understand that in order to be eligible for coverage through the Ohio State Medical Association Health Benefits Plan, I must meet the eligibility requirements set forth in the plan documents of the Ohio State Medical Association Health Benefits Plan and: 1) for coverage as an employee, I must be an active, full-time employee drawing a regular paycheck; and 2) for life, AD&D, disability, dental and/or vision coverage, I must also meet the eligibility requirements of Medical Mutual/CLIC.

9. My dependents and I understand and agree that any information obtained will not be released by the Ohio State Medical Association Health Benefits Plan or Medical Mutual/CLIC 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 Ohio State Medical Association Health Benefits Plan Board of Trustees at: Ohio State Medical Association, 3401 Mill Run Drive Hilliard, OH 43026. 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 Ohio State Medical Association Health Benefits 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 Ohio State Medical Association Health Benefits 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).