CONSUMERS LIFE®
A MEDICAL MUTUAL COMPANY
15885 W. Sprague Road
Strongsville, Ohio 44136-1772

Employee Enrollment Form

Please Type or Print All Information

☐ New Enrollment ☐ Change

Effective Date	Group Number

Last Name	First Name	M.I.	Date of Birth / /	Social Security Number

Street Address	City	State	Zip Code

Phone ( )	E-mail

Employer	Occupation/Job Title	Class	Gender ☐ male ☐ female

Original Date of Hire	Date of Rehire (If Applicable)	Earnings ☐ Weekly ☐ Monthly ☐ Annual $ _____

COVERAGE SELECTION: Your group insurance program 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.**

BASIC COVERAGE(S)		(A)dd (D)elete	Total Amount of Coverage Applied for
Basic Life	☐ YES ☐ NO		
Basic AD&D	☐ YES ☐ NO		
Supplemental/Voluntary Life	☐ YES ☐ NO		
Supplemental/Voluntary AD&D	☐ YES ☐ NO		
Short-Term Disability	☐ YES ☐ NO		
Long-Term Disability	☐ YES ☐ NO		
Dependent Life	☐ YES ☐ NO		

BENEFICIARY DESIGNATION (For Employee Only: Must be completed if you have applied for life and/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		/ /		%

TERMS AND CONDITIONS

I hereby apply to Consumer's Life Insurance Company (CLIC) for the coverage indicated on this Application.

I authorize: (1) payroll deduction(s) and remittance of any required contribution for coverage to CLIC, and/or any affiliates or divisions of CLIC; (2) release of information, without limitation, from any medical/medically related facility, prior health insurance carrier, the Medical Information Bureau, Inc. (MIB), government agency or person to CLIC and/or any affiliates or division of CLIC: (a) to evaluate this application; (b) to adjudicate claims submitted on behalf of me or my dependents; and/or; (c) for credentialing purposes. I authorize 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.

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 each and every 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.

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 or any portion of any answer to any question on this Application or any information 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 benefits that is inconsistent with, or different from, any written information provided by CLIC; (d) to bind CLIC 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 issuance of a policy; (e) to answer any questions in, or insert any information on, this Application on my behalf; or (f) to approve coverage. All contract terms must be in writing and signed or accepted in writing by an authorized representative of CLIC to be binding on CLIC.

I agree that: (a) any untrue or incomplete information, statement 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 CLIC; (b) to be eligible for life and/or disability income coverage, I must be actively at work as defined in the group policy. 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; (c) if coverage is issued, it will be based on full reliance on the information contained in this Application.

My dependents and I understand and agree that any information obtained will not be released by the Company 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 CLIC'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 CLIC's Privacy Office.

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.

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 insurance coverage until I receive an approval letter and insurance certificate from CLIC.

Employee 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)