



COMMERCE BENEFITS GROUP, INC.
P.O. BOX 900
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Fax: (440) 930-7501

ENROLLMENT / CHANGE FORM

INSTRUCTIONS

- ALWAYS PRINT CLEARLY USING A BLUE OR BLACK PEN.
NEW HIRES, LATE ENTRANTS AND DEPENDENT ADDITIONS — COMPLETE THE ENTIRE APPLICATION AND MEDICAL HISTORY QUESTIONNAIRE. (BASED ON ENROLLMENT GUIDELINES)
OTHER CHANGES — ONLY COMPLETE THE AREAS THAT APPLY TO YOUR CHANGE. E.G.: DELETING DEPENDENT(S), ADDRESS CHANGES, PHYSICIAN CHANGES
IF WAIVING COVERAGE, COMPLETE WAIVER AREA.
PLEASE DISCLOSE ALL MEDICAL CONDITIONS.
APPLICANT MUST PROVIDE PROOF OF FULL TIME STUDENT STATUS FOR DEPENDENTS AGE 19-23.
PROOF OF FINANCIAL RESPONSIBILITY MUST BE PROVIDED FOR DEPENDENTS WHOSE LAST NAMES ARE DIFFERENT THAN APPLICANT.
IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE 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. (OHIO ADMIN. CODE SECTION 3901-1-56)
IF CURRENTLY ON COBRA, PROVIDE ORIGINAL COBRA ELECTION FORM.

WAIVER

Check One Box in Section A and Complete Sections B and C.

A. Waived Coverages: I am waiving coverage on the following: (Check one)

- HEALTH and LIFE through Cardinal Health Plan
HEALTH through Cardinal
LIFE through Cardinal
HEALTH through Cardinal for the following dependents only: (Remember to complete the rest of this application)

1) 2) 3) 4) 5)

B. Current Health Coverage Status: I have...(Check One)

- Coverage through my Current Employer: Other Insurance Company Name:
Coverage through my Spouse's Employer: Spouse's Employer Name Spouse's Name Spouse's SS #
No coverage Other coverage Insurance Company Name:

C. Authorization: The terms of this waiver are explained in Explanation of Waiver section on back page. I have read and understand those terms.

Current Employer / Company Name:
Print Employee Name: Employee Social Security #:
Print Spouse Name: Spouse Social Security #:
Signature of Employee: Date:

**PLEASE NOTE: Failure to provide all of the requested information could cause a delay in coverage.**

*FOR OFFICE USE ONLY*

GROUP NO.:

EE Code

EFF. DATE:

Plan Code

EMPLOYER NAME			LOCATION / DIVISION CODE						
APPLICANT			SOCIAL SECURITY NUMBER	EMPLOYEE'S DATE OF BIRTH	SEX		EMPLOYEE HEIGHT	EMPLOYEE WEIGHT	
Last Name	First Name	Middle Initial			<input type="checkbox"/> MALE	<input type="checkbox"/> FEMALE			
EMPLOYEE'S HOME ADDRESS			CITY	STATE	ZIP	HOME TELEPHONE	OCCUPATION	DATE EMPLOYED	HOURS WORKED
MARITAL STATUS			DEPENDENT'S FULL NAME		SEX	SOCIAL SECURITY #	DATE OF BIRTH	HEIGHT	WEIGHT
<input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed					<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE				
WHO IS TO BE INSURED					<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE				
<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & Children <input type="checkbox"/> Employee, Spouse & Children					<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE				

**New Enrollment Information**

1. Requested Effective Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

2.  Medical     Dental (If Available)

Life           Vision (If Available)

**Change to Existing Policy Information**

1. Requested Date of Change \_\_\_\_ / \_\_\_\_ / \_\_\_\_

2.  Add Dependent to Policy (List Dep. in section above)

Benefit Change (Indicate choice to the immediate left)

Name Change: Former Name: \_\_\_\_\_

Address Change

Other: \_\_\_\_\_

**1. Have you or any of your listed dependents had symptoms, conditions, received medical advice, been diagnosed or treated by a physician for any of the following conditions within the last 10 years?**

CONDITIONS	YES	NO	CONDITIONS	YES	NO	CONDITIONS	YES	NO
1. A.I.D.S./A.R.C./H.I.V.			18. CONGESTIVE HEART FAILURE			36. JUVENILE DIABETES		
2. ALCOHOL OR DRUG DEPENDENCY			19. CORONARY ARTERY DISEASE			37. KIDNEY / URINARY DISORDER		
3. ALLERGIES			20. DIABETES			38. LIVER DISORDER		
4. ALZHEIMER'S DISEASE			Last Sugar Reading: _____			39. LUNG DISORDER		
5. ANOREXIA/BULIMIA			Date ____/____/____			40. MENTAL/EMOTIONAL DISORDER		
6. ARTHRITIS			21. DIVERTICULITIS			41. MULTIPLE SCLEROSIS		
7. ASTHMA			22. DOWN'S SYNDROME			42. NEUROLOGICAL DISORDER		
8. BACK/SPINAL DISORDERS			23. EAR, NOSE, THROAT, SINUS			43. OSTEO ARTHRITIS		
9. BLOOD PRESSURE/HYPERTENSION			24. EMPHYSEMA			44. PARALYSIS		
Last Three Readings / Date			25. EPILEPSY			45. PARKINSON'S DISEASE		
BP ____/____    ____/____    ____/____			26. FEMALE CONDITIONS			46. RHEUMATOID ARTHRITIS		
Date ____/____/____    ____/____/____    ____/____/____			27. GASTRIC / PEPTIC ULCER			47. SKIN DISORDERS / ACNE		
10. BOWEL / STOMACH DISORDER			28. HEART ATTACK			48. SPINA BIFIDA		
11. CANCER, LEUKEMIA or MELANOMA			29. HEART BYPASS SURGERY			49. STROKE		
12. CEREBRAL PALSY			30. HEART DISORDER			50. TUMORS / GROWTHS / CYSTS		
13. CHEMICAL DEPENDENCY			31. HEMOPHILIA			51. TUBERCULOSIS		
14. CROHN'S DISEASE			32. HEPATITIS			52. ULCERATIVE COLITIS		
15. CHRONIC BRONCHITIS			33. HERNIA			53. VENEREAL DISEASE		
16. CHRONIC DEPRESSION / ANXIETY			34. HIGH RISK PREGNANCY			54. OTHER		
17. CONGENITAL DISEASE / DEFECT			35. ISCHEMIA					

**2. If any of the conditions above are checked "Yes" please explain in detail below. Attach separate sheet in this format if more space is required.**

CONDITION / DISPOSITION #	INDIVIDUAL (FULL NAME)	PHYSICIAN'S NAME AND ADDRESS	TREATMENT DATES (FROM / TO)	DIAGNOSIS, TREATMENT, PROGNOSIS, MEDICATION, DOSAGES & REASON (Be Specific)	HOSPITALIZED
					<input type="checkbox"/> YES <input type="checkbox"/> NO From To
					<input type="checkbox"/> YES <input type="checkbox"/> NO From To
					<input type="checkbox"/> YES <input type="checkbox"/> NO From To
					<input type="checkbox"/> YES <input type="checkbox"/> NO From To
					<input type="checkbox"/> YES <input type="checkbox"/> NO From To

**3. Have you or any of your listed dependents** consulted a physician for any condition not listed in question #1?

*(Use additional paper if necessary)*

CONDITION / DISPOSITION #	INDIVIDUAL (FULL NAME)	PHYSICIAN'S NAME AND ADDRESS	TREATMENT DATES (FROM / TO)	DIAGNOSIS, TREATMENT, PROGNOSIS, MEDICATION, DOSAGES & REASON (Be Specific)	HOSPITALIZED
					<input type="checkbox"/> YES <input type="checkbox"/> NO From To
					<input type="checkbox"/> YES <input type="checkbox"/> NO From To
					<input type="checkbox"/> YES <input type="checkbox"/> NO From To
					<input type="checkbox"/> YES <input type="checkbox"/> NO From To

**4. Do you or any of your listed dependents** currently take prescribed medication (Including fertility drugs)?

*(Use additional paper if necessary)*

PERSON	MEDICATION	DOSAGE PER DAY	CONDITION

**5. Are you or any of your listed dependents** pregnant?  YES  NO Due Date \_\_\_\_\_

**6. Has future surgery, diagnostic testing or medical treatment** been suggested/recommended for **any person** on this application?

YES  NO If yes, give name, ailment, treatment recommendation and/or type of operation.

**7. MEDICARE INFORMATION**

Are you covered by Medicare?  YES  NO If YES, Medicare No. \_\_\_\_\_ EFFECTIVE DATE: PART A \_\_\_/\_\_\_/\_\_\_ PART B: \_\_\_/\_\_\_/\_\_\_  Hemodialysis

Is your spouse or dependent covered by Medicare?  YES  NO If YES, Medicare No. \_\_\_\_\_ EFFECTIVE DATE: PART A \_\_\_/\_\_\_/\_\_\_ PART B: \_\_\_/\_\_\_/\_\_\_  Hemodialysis

**8. Do you or any listed dependent** have a condition covered by Workers' Compensation? If yes, please explain in detail.

WC Claim No. \_\_\_\_\_

**9. Are you or any other listed dependents** currently covered by any other medical insurance that will not be replaced by this coverage?

YES  NO If yes, please provide following information:

Names: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Policy #: \_\_\_\_\_ Telephone: \_\_\_\_\_

**COORDINATION OF BENEFITS INFORMATION (C.O.B.)**

Is your spouse employed?  YES  NO

Spouse's Employer: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

Does your spouse have medical insurance?  YES  NO

Insurance Carrier: \_\_\_\_\_ Policy #: \_\_\_\_\_ Telephone: \_\_\_\_\_

**Type of Coverage**

- Family Medical     Family Prescription Card     Family Dental     Family Vision  
 Single Medical     Single Prescription Card     Single Dental     Single Vision

**10. Life Insurance (If Applicable)**

Beneficiary Last Name	Beneficiary First Name	Date of Birth	Relationship	Benefit Split**
PRIMARY				%
SECONDARY				%

\*\* Unless otherwise noted, if two primary beneficiaries are named, the proceeds will be paid in equal shares to the primary beneficiaries surviving you.

**Applicant must provide proof of full-time student status for dependents age 19-23.**

## **EXPLANATION OF PRE-EXISTING CONDITION**

I understand and accept the Pre-Existing Condition exclusion for all medical conditions for which medical care, diagnosis, advice or drugs were received up to six (6) months prior to the effective date of the employee's or eligible dependent's coverage. Benefits related to a pre-existing condition may be covered after a period of twelve (12) consecutive months while covered under the Plan. Medical conditions that are not disclosed will be declined and not eligible for coverage. Any employee and/or eligible dependents shall be credited with the time covered by the previous employer's Plan provided that coverage has been continuous with no lapse in coverage greater than 63 days. Proof of such continuous coverage must be provided by the employee and/or eligible dependent.

## **EXPLANATION OF WAIVER**

I understand that if I sign the Waiver section on the front cover of this application, I am choosing not to have those persons covered under the health and life (if applicable) benefits designated and any later application for enrollment and acceptance will be subject to all underwriting requirements.

If you are declining enrollment for yourself and/or your dependents (including your spouse) due to other health insurance coverage, you may in the future be able to enroll yourself and/or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage terminates. 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/or your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

## **THE TERMS AND WHAT YOU DECLARE**

I hereby authorize the immediate release of information on myself and/or my dependents, without limitation, from any medical/medically related facility, government agency or person, for utilization review programs to monitor health services or quality improvement. I authorize the applicable carrier to provide a photocopy of this release to any physician or medical institution to obtain records for the purposes stated above.

I understand that to be eligible for health coverage, I must be an active full-time employee as defined by the Plan. If coverage is issued, it will be based upon full reliance on the information contained in this application.

It is further understood that it is my responsibility to notify the underwriter and/or claims administrator of any changes in medical status (employee and/or dependents) that may occur between the date of this signature and the proposed effective date in which I may become eligible for coverage.

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Date of application

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Signature of proposed insured