



1975 Tamarack Road P.O. Box 1099
 Newark, Ohio 43068-1099
 (800) 423-3151
 www.medben.com

WARNING: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an Insurer or health benefit plan, submits an application or files a claim containing false or deceptive statements is guilty of insurance or health care fraud under state and/or federal law.

MOUNT VERNON NAZARENE UNIVERSITY - ENROLLMENT APPLICATION

PLEASE READ CAREFULLY AND COMPLETE IN INK TO PREVENT YOUR COVERAGE FROM BEING DELAYED.

1

Employee Information (Please Print in Ink): Social Security Number
 Name _____
Last First Middle Initial
 Home Address _____ Telephone () _____
Street City State Zip

Employee Date of Birth Mo. Day Yr.	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed	Date of Hire Mo. Day Yr	Group # 10114 Medical/Dental/Vision
--	--	---	---------------------------------------	---

Coverage Elected				Effective Date (Office use only)
COVERAGE ELECTION	Employee	Employee plus 1	Family	
Medical/Basic Dental				_____
Medical /Dental Buy Up				
Dental Only				
VISION PLUS ELECTION				
Vision Plus				

2

IF APPLYING FOR DEPENDENT COVERAGE LIST BELOW

If you do not wish to cover your eligible dependents, please complete the waiver area in Section 3.

Spouse (Print full name)	DOB	Medical/Rx	Dental	Vision	Sex		S.S. Number (Spouse Only)											
					Male	Female												
Other Dependent(s) (Print full name)								Natural Child	Adopted Child*	Step-Child	Legal Guardian*	You &/or your Spouse provide over 50% of Support?	Full-Time Student? (Y/N)**					

*Please attach to this application copies of the court orders or legal documents creating this relationship. For adopted children, only necessary for initial enrollment after adoption or placement. **If dependent is 19 - 23, list the name of the dependent, the educational institution such child is currently attending and the number of credit hours: _____

Spouse employed Yes No Employed By _____ Date of Marriage _____

Are you, your spouse or children covered or insured under any other medical coverage, dental or vision coverage (including Medicare and other government plans)? Yes No If yes, indicate who is covered under this other coverage, and who the carrier is: _____

Are any of the other Dependents listed above in the legal custody of another Person? Yes No If yes, Please submit documents.

3 NOTICE REGARDING PRIOR HEALTH COVERAGE

If any person for whom application for coverage has been made above was covered under other health coverage within 62 days (not including any waiting period under this plan or any other plan) of the date such person's coverage would become effective under this plan, he or she may be entitled to credit towards any pre-existing conditions restriction under this plan for any coverage time under one or more prior plans. In order to claim this credit, a certificate of creditable coverage from the prior plan(s), or other evidence documenting the person's prior coverage, should be attached to this form.

If coverage was lost under the prior health plan within 30 days of the date of this application, list reason the coverage was terminated under the prior plan. _____

4 WAIVER OF COVERAGE

If you are declining enrollment for yourself or your dependents (including your spouse) because you have other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within the time period required by your plan (30) days after other coverage ends. 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 the time limit allowed by your plan after the date of the marriage, birth, adoption, or placement for adoption. Your plan may also allow additional enrollment periods as specified in the plan document. This plan will also allow enrollments as necessary to comply with the terms of medical child support orders, or qualified medical child support orders, as defined in applicable state or federal law. Other than as described, if you fail to enroll at this time you may not be eligible to enroll thereafter, or may be subject to certain restrictions which are described in your plan.

- I waive coverage for:
- | | | |
|---|--|---|
| <input type="checkbox"/> All Medical | <input type="checkbox"/> All Dental | <input type="checkbox"/> All Vision Plus |
| <input type="checkbox"/> Spouse Medical | <input type="checkbox"/> Spouse Dental | <input type="checkbox"/> Spouse Vision Plus |
| <input type="checkbox"/> Child(ren) Medical | <input type="checkbox"/> Child(ren) Dental | <input type="checkbox"/> Child(ren) Vision Plus |

Are you waiving the coverage listed above because you and/or your dependents have other health coverage?

Yes No If so, Please list below what coverage(s) you are waiving, the dependent (s) you are waiving and with whom they are covered.

Medical Yes No Carrier _____ Names of whom you are waiving coverage _____

Vision Yes No Carrier _____ Names of whom you are waiving coverage _____

Employee Signature _____ **Date** _____

5 Read this Agreement and Authorization Carefully

I hereby request coverage and authorize that any requested contribution for the insurance to which I may be entitled be deducted from my earnings. I am employed by the employer shown and am working at least the number of hours per week required by my Employer and shown on the Employer Application. I authorize (1) any physician, hospital, or other health practitioner or facility, (2) any insurance company or health care plan, (3) any state or federal agency providing health care benefits, and (4) any employer to provide Medical Benefits Mutual Life Insurance Co. or its legal representative any information in their possession which is relevant to this application for insurance regarding myself or my listed Dependent(s). This information will be used to determine the eligibility for coverage and/or benefits for myself and my listed Dependent(s) and will be utilized by employees and agents of Medical Benefits Mutual Life Insurance Co. and its subsidiaries with responsibility for (1) reviewing applications and determining eligibility for coverage, (2) payment of claims, and (3) any other health care operations. I hereby authorize and release any provider of health care services, claim administrators, insurers, reinsurers, and others who have a legitimate need for such information for the purpose of review, investigation, or evaluation of a claim, to supply each other with information about the health care services provided to, me and my listed Dependent(s). I understand that information disclosed by MedBen to any individuals listed in the preceding paragraph pursuant to this authorization may be subject to redisclosure by such individuals, and will no longer be protected by this authorization. This authorization is effective on the date signed and shall remain in effect for 30 months from that date. (You or any individual authorized by law to act on your behalf have a right to receive a copy of this authorization.) A photographic copy of this authorization shall be as valid as the original. I understand that if I fail to provide this authorization, MedBen will be unable to process my application for coverage. I further understand that I have the right to revoke this authorization by submitting such revocation to the Chief Privacy Officer, Medical Benefits Mutual Life Insurance Co. at the address listed on this application. Such revocation will not be effective to the extent that action has been taken in reliance upon this authorization prior to MedBen's receipt of my revocation or to the extent that MedBen has the right to contest my coverage or a claim thereunder under applicable law. I hereby certify that I have personally answered all of the questions on this form and that my answers are true and complete to the best of my knowledge and belief. I have legal proof which I can furnish upon request of my relationship to any person listed as a Dependent above. I understand that any misstatements, or failure to report, may be used as a basis for rescission or cancellation of the insurance for me and my Dependent(s), if any. I further understand that, should I drop any of the coverages listed on this application while still eligible, I may not be allowed to subsequently reapply for the same coverage.

Employee Signature _____ Date _____