Submit to Central Office NOT Medical Mutual.

Employee Name	Group/Company Name
	603406

MEDICAL MUTUAL OF OHIO®

1. ACTION REQUESTED

☐ New Policy Application or ☐ COBRA/Continuation	☐ Policy Change
Requested Effective Date: _____ Select Coverage: (Check all that apply) ☐ Health ☐ Drug ☐ Dental	Requested Date of Change: _____ 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 (m/d/y)	Gender ☐ M ☐ F

Employment Status	Marital Status
☐ Active, **Full Time Date of (Re)Hire:** _____ ☐ Retired ☐ COBRA, Expiration Date: _____	☐ Single ☐ Separated ☐ Widowed ☐ Married, Date Married: _____ ☐ Divorced, Date Divorced: _____
Job Title	

Home Address	City	State	Zip Code

Email Address	Home Phone Number	

3. COVERED DEPENDENTS

Relationship	First Name	Last Name (if different)	Date of Birth	Social Security #	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