PO Box 3620
Akron, Ohio 44309-3620

ENROLLMENT APPLICATION (LARGE GROUP)

HOW TO ENROLL IN SUMMACARE:

Please use this page as a guide in completing your enrollment application. **If you have any questions, please call SummaCare Member Services at 330-996-8700 or 800-996-8701.**

- PLEASE PRINT OR TYPE information which is requested. Press firmly.
- Complete ALL information which is requested by "Employee". Applications which are incomplete may cause a delay in processing.
- Select a Primary Care Physician (PCP) for you and each of your covered dependents and enter the PCP code where appropriate. Note: PPO members do not select a PCP.
- If your dependent is a full-time student at an accredited college, please attach a copy of his/her schedule to this application to verify student status.
- **MAKE SURE YOUR SPOUSE SIGNS THE APPLICATION.**

WAIVER OF COVERAGE

COMPLETE THIS SECTION ONLY IF YOU ARE ELIGIBLE FOR GROUP COVERAGE AND CHOOSE NOT TO ENROLL FOR HEALTH COVERAGE. ALSO INDICATE IF YOU ARE WAIVING LIFE INSURANCE COVERAGE THROUGH SUMMACARE.

NAME: ______________________ DATE OF BIRTH: ______________________

SOC. SEC. NUMBER: ______________________ DATE OF HIRE: ______________________

ADDRESS: ______________________ CITY/STATE/ZIP: ______________________

PHONE NUMBER: ______________________ EFFECTIVE DATE: ______________________

EMPLOYER (GROUP) NUMBER: ______________________

Coverage is being waived because:

__ Have other coverage through spouse

__ Enrolled with SummaCare through another employer (If so, identification no: ______________________)

__ Enrolled in Group Coverage through another employer-sponsored plan.
(If so, name of Insurance/Carrier ______________________)

__ Other: ______________________

I also wish to waive life insurance coverage through SummaCare. ____ Yes ____ No ____ N/A

I have had an opportunity to enroll in SummaCare and hereby waive coverage available through this employer group.

______________________ ______________________
Employee Signature Date

SUMMACARE ENROLLMENT APPLICATION

Please use a ballpoint pen; press hard!

Failure to complete all sections may delay coverage date!

LARGE GROUP APPLICATION - 51 + EMPLOYEES

TO BE COMPLETED BY THE EMPLOYER

EFFECTIVE DATE OF COVERAGE	Employer (Group) Name and Number
NEW HIRE ☐ Yes ☐ No (If no, please attach documentation such as HIPAA certificate, etc.)	DATE OF FULL TIME EMPLOYMENT

EMPLOYEE STATUS (CIRCLE APPROPRIATE ITEM(S))
ACTIVE RETIRED COBRA MEDICARE WRAP OPEN ENROLLMENT FULL TIME PART TIME REHIRE RECALL OHIO LAW

TO BE COMPLETED BY THE EMPLOYEE (PLEASE PRINT)

Type of Plan ____ HMO/POS ____ SummaCare Preferred PPO (This product is underwritten by the Summa Insurance Company)

EMPLOYEE NAME	SOCIAL SECURITY NUMBER

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ LEGALLY SEPARATED

ADDRESS NUMBER & STREET	CITY	STATE	ZIP CODE	COUNTY

HOME PHONE # ( )	WORK PHONE # ( )	EXT.	OCCUPATION

TYPE OF COVERAGE SELECTED (check one):
☐ FOR YOU ONLY ☐ FOR YOU PLUS YOUR SPOUSE ☐ FOR YOU PLUS YOUR CHILD(REN) ☐ FOR YOU PLUS YOUR SPOUSE AND CHILD(REN)

COMPLETE THE FOLLOWING INFORMATION FOR ALL PERSONS TO BE COVERED, INCLUDING YOURSELF. USING THE SUMMACARE PROVIDER DIRECTORY, SELECT A PRIMARY CARE PHYSICIAN (PCP) FOR EACH PERSON TO BE COVERED AND LIST THAT PCP'S NAME IN THE SPACE INDICATED. IF THE ADDRESSES OF ANY OF THE FOLLOWING INDIVIDUALS ARE DIFFERENT FROM THE ADDRESSES ABOVE, PLEASE LIST THE NAMES AND ADDRESSES ON A SEPARATE SHEET AND ATTACH THEM TO THE APPLICATION FORM.

IF YOUR DEPENDENT IS OVER THE LIMITING AGE BUT IS A FULL TIME STUDENT, PLEASE ATTACH A CLASS SCHEDULE TO THIS APPLICATION AS PROOF OF STUDENT STATUS.

Last Name/ Social Security Number	First Name	MI	Relationship (child/step/ other)	Date of Birth (mo/day/yr)	Sex (m/f)	Ht.	Wt.	Full Time Student (Y/N)	PCP Name (Those enrolling in a PPO Plan DO NOT Pick a PCP)	PCP Code	New Patient (Y/N)
			SELF								

WILL YOU, YOUR SPOUSE, OR YOUR DEPENDENTS BE COVERED BY SOME OTHER TYPE OF HEALTH INSURANCE WHILE COVERED UNDER SUMMACARE?
☐ NO ☐ YES If "yes" please complete the following information: ☐ Regular ☐ COBRA If yes, start date End date

INSURANCE COMPANY NAME & ADDRESS	COVERED PERSON	ID #	GROUP #	COVERAGE TYPE
				☐ MEDICAL ☐ VISION ☐ PHARMACY ☐ DENTAL ☐ OTHER

Have you been covered under any other health plan within the last 12 months? ☐ NO ☐ YES. If yes, Name of Carrier: ____________________
Policy Number:____________________ Effective Date: ______________ Termination Date: ______________

IS YOUR SPOUSE EMPLOYED? ☐ NO ☐ YES, If "yes" please give name and address of spouse's employer

NAME ADDRESS

MEDICARE ELIGIBILITY (Complete this section if you, your spouse or dependents are covered by Medicare Part A and/or B.)

NAME OF COVERED PERSON	MEDICARE #

EMPLOYEE & SPOUSE (IF APPLICABLE) MUST SIGN AND DATE THE FOLLOWING CERTIFICATION AND AUTHORIZATION:

By electing the SummaCare option, I understand that I and all my eligible dependents accept the SummaCare option in lieu of the benefits provided by my employer's other medical benefits plans. I certify that all information supplied on this form is true and complete to the best of my knowledge. I understand that all benefits for myself and my eligible dependents will be provided in accordance with the plan documents. I am familiar with and agree to abide by the terms and conditions governing membership and receipt of health services in the plan, and agree to the provisions stated on the reverse side of this form, which I have read and understand.

EMPLOYEE ____________________ DATE __________ SPOUSE (if Applying for coverage) ____________________ Date __________

Important! Spouse must sign application if applying for coverage or application will NOT be accepted.

Distribution: White — SummaCare Yellow — Employer Pink — Employee

TERMS AND CONDITIONS

a. Employee and spouse understand that they are responsible for reporting to the employer, within 31 days, any changes in their employee health status, marital status, in the number or eligibility status of their dependents, or any changes in their health coverage or residence.

b. By signing the application, you and your spouse hereby authorize any hospital, physician, surgeon, pharmacist or other health care provider, any insurance company, any third-party administrator, or final payer of claims to release to and/or receive from SummaCare, third-party administrator or appropriate other entity any information concerning claims or the delivery of medical care for yourself and your covered underage dependents. Employee and spouse understand that such information may be used to provide appropriate treatment, coordination of care, quality measurement and other appropriate uses related to treatment and care. Employee and spouse further understand that medical information may be obtained from the review of medical records and claims records that may contain information regarding behavioral health, HIV, Acquired Immune Deficiency Syndrome (AIDS), pharmacy and substance abuse. Employee and spouse acknowledge that signing this Enrollment Application provides authorization for the release of medical information as stated herein. Consent is effective for the term of my membership with SummaCare. Upon making changes to your enrollment status with SummaCare, you and or your spouse will be asked to submit a revised signed enrollment form. Doing so maintains current consent for release of medical information as stated above.

You have the right to approve the release of personal health information beyond the uses identified in this consent. Special consent is required to provide data requested for workers' compensation or auto insurance claims; and release of information that could result in you being contacted by another organization for marketing purposes and research studies. In the event that you are deemed incompetent or cannot provide consent, SummaCare requires documented proof of power of attorney or guardianship prior to release of information. Legal council will review the documentation prior to release of information.

Any data shared with employer groups is not implicitly or explicitly member identifiable, unless that member involved provides specific consent. Self-Funded Employers requiring identifiable data are held to strict confidentiality standards that protect the data from internal disclosure for any use that would adversely affect members.

The release of information is personal to you and your underage dependents. You may not authorize release of personal health information for your spouse unless documented proof of power of attorney or guardianship is provided with the enrollment application. If your spouse is receiving health care coverage under this plan, he/she must sign the enrollment application authorizing the release of personal health information as stated above.

Personal health information may be released without your consent by order of a court with appropriate jurisdiction.

SummaCare warrants that any other person and or entity that receives information from SummaCare sign a confidentiality agreement which requires them to abide by and release information in accordance with SummaCare's confidentiality policies and procedures.

c. Employee and spouse agree that benefits payable on their account or on account of one of their covered dependents under the employer's SummaCare plan may be paid directly to the provider of care.

d. Employee and spouse understand and agree that no benefits shall take effect until the application is approved for SummaCare participation. Upon acceptance, as soon as possible, a SummaCare identification card(s) will be issued to evidence coverage hereunder. The identification card(s) remain the property of SummaCare and must be surrendered to the employer when eligibility for SummaCare participation terminates.

e. If there is a payroll, disability or pension deduction for enrollment in SummaCare, employee authorizes it to be made.

f. Any employee obligated for any part of a prepayment may cancel such agreement within 72 hours after he/she has signed an agreement or offer to enroll. Cancellation occurs when written notice of cancellation is given to SummaCare or its agents or other representatives. Notice of cancellation shall be considered given when the prospective member mails a letter to SummaCare.

TEMPORARY SUMMACARE IDENTIFICATION

Keep the last copy (pink) of this application for your records. Use it as a temporary identification card once your coverage becomes effective, until you receive your permanent identification card in the mail.

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.

SummaCare Member Services
(330) 996-8700 or (800) 996-8701
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www.summacare.com