

# APPLICATION FORM OPEN ENROLLMENT

*This plan is underwritten by the Summa Insurance Company and administered by SummaCare. Failure to complete all sections may delay coverage date.*

PLAN CHOICE:	BASIC OPEN ENROLLMENT <input type="checkbox"/> YES <input type="checkbox"/> NO PPO OPEN ENROLLMENT <input type="checkbox"/> YES <input type="checkbox"/> NO
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EFFECTIVE DATE:  
 FEDERALLY ELIGIBLE INDIVIDUAL: Effective date at time of application acceptance (no pre-existing conditions clause).  
 If Federally Eligible, please attach or mail a copy of your Certificate of Creditable Coverage from your prior carrier.

CERTIFICATE OF CREDITABLE COVERAGE ATTACHED?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
CERTIFICATE OF CREDITABLE COVERAGE MAILED OR FAXED?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

NON-FEDERALLY ELIGIBLE INDIVIDUAL: 90-day waiting period for date of application acceptance (pre-existing condition applies). Effective date and premium will be confirmed upon application acceptance date.

Refer to the definition of Federally Eligible and Non-Federally Eligible Individuals on [www.summacare.com](http://www.summacare.com) or on the last page of this application.

**INTERNAL USE ONLY**  
 Actual Effective Date of Coverage:

NAME	SOCIAL SECURITY NUMBER			
MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> LEGALLY SEPARATED				
ADDRESS NUMBER & STREET	CITY	STATE	ZIP CODE	COUNTY
HOME PHONE NUMBER	WORK PHONE NUMBER			EXT.
EMAIL ADDRESS	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)
- FOR YOUR CHILD(REN) ONLY

Complete the following information for all persons to be covered, **including yourself**. If the addresses of any of the following individuals are different from the address above, please list the names and addresses on a separate sheet and attach them to the application form.

LAST NAME	FIRST NAME	MI	RELATIONSHIP (CHILD/STEP/ OTHER)	SOCIAL SECURITY NUMBER	DATE OF BIRTH (MO/ DAY/YR)	SEX (M/F)
			Self			

Will you, your spouse or your dependents be covered by another type of health insurance while covered under this policy?

NO  YES

If **YES**, please complete the following information:

GROUP (THROUGH AN EMPLOYER)  COBRA OR STATE CONTINUATION OF COVERAGE  
 MEDICARE  MEDICAID

Start date: \_\_\_\_\_ End date: \_\_\_\_\_

INSURANCE COMPANY NAME & ADDRESS	COVERED PERSON	ID #	GROUP #	COVERAGE TYPE
				<input type="checkbox"/> MEDICAL
				<input type="checkbox"/> VISION
				<input type="checkbox"/> PHARMACY
				<input type="checkbox"/> DENTAL
				<input type="checkbox"/> OTHER

**(NOTE: If you are eligible for Medicare, Medicaid, Group Health Plan or COBRA, you are not eligible to apply for this plan.)**

### OTHER HEALTH COVERAGE FOR NON FEDERALLY ELIGIBLE INDIVIDUALS

If you or any of your dependents have had any other health coverage within the last 12 months, you may be eligible for a pre-existing credit. If so, please attach a copy of a HIPAA Certificate of Creditable Coverage to this application. This can be obtained through your prior carrier.

Have you had previous coverage from Summa Insurance Company?  NO  YES

If **YES**, what type of coverage did you have?

GROUP (THROUGH AN EMPLOYER)  COBRA  
 CONVERSION  OPEN ENROLLMENT  
 OTHER

If **YES**, complete the following (use a separate sheet if more than one prior carrier):

NAME OF PRIOR CARRIER: \_\_\_\_\_ TELEPHONE NUMBER: \_\_\_\_\_

IDENTIFICATION NUMBER: \_\_\_\_\_ COVERED PERSONS: \_\_\_\_\_

EFFECTIVE DATE: \_\_\_\_\_ DATE OF TERMINATION: \_\_\_\_\_

## BILLING INFORMATION

Open enrollment premium must be paid at the time of application acceptance.

Method of payment:

VISA

MASTERCARD

DIRECT DEBIT FROM SAVINGS/CHECKING

ONE TIME ONLY CREDIT CARD DRAW

Total amount enclosed or to be charged: \$ \_\_\_\_\_

Please fill out the information below:

**For credit or debit card automatic draw, card must have either VISA or MASTERCARD logo to be processed.**

CARD HOLDER'S NAME: \_\_\_\_\_ ACCOUNT NUMBER: \_\_\_\_\_

EXPIRATION DATE: \_\_\_\_\_ CVV NUMBER: \_\_\_\_\_

*(Last three digits of the number located on the signature strip on the card)*

I (we) hereby authorize Summa Insurance Company and the financial institution issuing the credit/debit card named above to initiate charges and, if necessary, credits to my account listed above. I (we) acknowledge that the origination of credit/debit card transactions to my (our) account must comply with the provision of U.S. law.

Your account must show as paid in full in order to be eligible for this program. Payment will be drawn on the first business day of each month. ACH transactions returned for insufficient funds will be charged a \$25 NSF fee. This authority will remain in full force and effect until COMPANY has received written notification from me of its termination in such time and manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act upon it. Send any termination or change request to: Premium Billing, Summa Insurance Company, PO Box 3620, Akron, OH 4309-3620.

POLICY HOLDER'S NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY, STATE, ZIP: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

## DIRECT DEPOSIT AUTHORIZATION FORM

Company name: Summa Insurance Company, ID no. 32-1726655

For checking/savings automatic draw:

FINANCIAL INSTITUTION NAME: \_\_\_\_\_ BRANCH NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY, STATE, ZIP: \_\_\_\_\_

ROUTING NUMBER: \_\_\_\_\_ ACCOUNT NUMBER: \_\_\_\_\_

I (we) hereby authorize Summa Insurance Company and the financial institution named above to initiate electronic debit entries and, if necessary, credit entries to my account listed above. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provision of U.S. law. **Please include a voided check to eliminate discrepancies in account information.**

## TERMS AND CONDITIONS

To be considered for enrollment in this Policy:

Applicant and dependents understand that they are responsible for reporting to Summa Insurance Company, within 31 days, any changes in their marital status, in the number of eligible dependents, or any change in health coverage or residence.

Applicant understands that no agent or Plan representative may permit or encourage an applicant to answer any questions inaccurately, untruthfully or incompletely, and applicant represents that such did not occur. The selling agent has no authority to promise me coverage or to modify Summa Insurance Company underwriting policy or terms of any coverage.

I understand that I am apply applying for individual health coverage (under Summa Insurance Company Open Enrollment), which is not part of any employer-sponsored plan. I understand that I am responsible for 100% of the premiums.

**Applicant and dependents authorize any physician, other healthcare professional, health plan, insurance compnay, medical benefits carrier, welfare benefit plan, hospital, pharmacy, pharmacy benefit manager or any other health-care organization to give Summa Insurance Company or its agents information concerning the medical history, prescription history, services or treatment provided to anyone listed on this enrollment form. I further authorize Summa Insurance Company to disclose such information to vendors, consultants and governmental authorities with jurisdiction when necessary for my care or treatment, payment for services or to conduct related activities.**

Even if I pay money with this application, that money is only a deposit against future premiums IF this application is accepted. Cashing my check does not mean my application is approved. If this application is declined, Summa Insurance Company shall not have any liability to me or anyone else listed on this application, except for the obligation to return the money submitted, minus any claims paid. If this application is not accepted, neither I nor anyone listed on it will be entitled to benefits from Summa Insurance Company.

I understand that pre-existing conditions are limited to 12 months after enrollment for conditions in existence within six months immediately prior to my enrollment for which medical advice, diagnosis, care or treatment was recommeded or received. Pregnancy is considered a pre-existing condition. (Applies to NON-FEDERALLY ELIGIBLE INDIVIDUALS).

Applicant and dependents understand and agree that no benefits shall take effect until application is approved for coverage and wait period met. An identification card(s) will be issued, as soon as possible, to evidence coverage upon acceptance. Any applicant obiligated for any part of a prepayment may cancel such agreement within 10 days after he/she has signed an agreement application to enroll. Cancellation occurs when written notice of cancellation is submitted to the Summa Insurance Company or its agents or other reopresentatives. Cancellation within the 10 day period will render the policy void from the beginning. The prepayment will be returned in full and applicant will be responsible for any claims incurred during that time peroid. If you leave Summa Insurance Company's Open Enrollment for a Summa Insurance Compay or SummaCare group policy and there is no lapse in coverage, the individual application will cancel on the effective date of the group plan. However, you must still notify us of this change so you will not be double billed.

Applicant acknowledges that he/she has received the Notice of Privacy Practives, which outlines how Summa Insurance Compnay uses and discloses his/her health information and his/her rights as a member.

### **APPLICANT MUST SIGN AND DATE THE FOLLOWING CERTIFICATION AND AUTHORIZATION:**

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 my eligible dependents and me will be provided in accordance with the policy. I am familiar with, have personally read and completed this application. I agree to abide by the terms and conditions governing this application and the delivery of health services covered under this policy, and agree to the provisions stated on this form, which I have read and understand. I understand that under the Summa Insurance Company Open Enrollment Plan I will be entitled to lesser benfits if I use an out-of-network hospital or physician than if I use a network hospital or physician. I ALSO UNDERSTAND THAT MATERIAL OMISSIONS AND INTENTIONAL MISREPRESENTATIONS REGARDING INFORMATION PROVIDED ON THIS APPLICATION COULD CAUSE A COVERED SERVICE TO BE DENIED AND/OR COULD VOID ANY COVERAGE IS-SUED. I FURTHER UNDERSTAND THAT I WILL BE RESPONSIBLE TO REIMBURSE SUMMA INSURANCE COMPANY FOR ALL PAID CLAIMS IFI OMIT (WHETHER INTENTIONAL OR NOT), INFORMATION ON THIS APPLICATION.

If applicant is a minor, I accept full legal and financial responsibility for the coverage and information provided on this application.

APPLICANT OR  
GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

SPOUSE SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

I hereby authorize and health care provider or medically related facility, pharmacy or pharmacy related facility, the Medical Information Bureau, any pharmaceutical information data source, consumer reporting agency, insurance or reinsurance company or employer having information about me or my minor children to provide all such information as may be requested to Summa Insurance Company, its contracted or legal representatives or any medical or pharmaceutical records retrieval service Summa Insurance Company may engage, including, but not limited to EMSI.

This authorization includes any and all information you may have about me, including, but not limited to information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition, as well as alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, sickle cell testing and treatment, lab data and EKGs. This information may also be disclosed to any medical records company engaged by Summa Insurance Company, including, but not limited to EMSI and its agents. Although federal regulations require that we inform you of the potential that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by such regulation, all information received by Summa Insurance Company pursuant to this authorization will be protected by federal and state privacy laws and regulations. A copy or facsimile of this authorization will be as valid as the original.

I understand that this authorization is required in order to enable Summa Insurance Company to make eligibility, enrollment, benefit determinations and underwriting and risk rating determinations relating to me and/or my minor children. If I refuse to sign or revoke this authorization, Summa Insurance Company may refuse to consider my application for enrollment.

I understand that I may revoke this authorization at any time by notifying Summa Insurance Company in writing of my desire to revoke. Such revocation must be sent by United States Postal Service Certified Mail to the following address: Summa Insurance Company, Attn: Compliance, 10 North Main Street, Akron, Ohio 44308. Such revocation will not be valid if Summa Insurance Company has taken action in reliance on the authorization.

Unless an earlier date is required by law, this authorization expires on the earliest of the following events: denial of my application, declination for enrollment or, if insured, when I am no longer an insured of Summa Insurance Company.

Signature(s):

APPLICANT\*: \_\_\_\_\_

SPOUSE: \_\_\_\_\_

DEPENDENT: \_\_\_\_\_

DEPENDENT: \_\_\_\_\_

DEPENDENT: \_\_\_\_\_

DEPENDENT: \_\_\_\_\_

\*If you are requesting coverage as a representative for any minor individual on this application and are not the parent or legal guardian, or if you are requesting coverage as a representative of the applicant, you must attach documentary evidence of your authority to act as the individual's representative for this authorization to be valid.



## DEFINITIONS OF FEDERALLY ELIGIBLE AND NON-FEDERALLY ELIGIBLE INDIVIDUAL

Ohio law requires Summa Insurance Company to accept a certain number of individuals for open enrollment coverage without regard to health status. If you qualify as a Federally Eligible Individual (FEI), your coverage will be effective immediately without any pre-existing condition exclusion period. If you do not qualify as a FEI, you may apply for Non-FEI open enrollment coverage.

You are a **Federally Eligible Individual** if you meet all of the following conditions:

1. You had health coverage for at least 18 months without a break in coverage greater than 63 days.
2. Your most recent health coverage was under a group health plan, governmental plan or church plan.
3. You are not eligible for coverage under any of the following plans:
  - a. A group health plan
  - b. Medicare
  - c. Medicaid
4. You do not have any other health coverage
5. Your most recent health coverage was not terminated because of nonpayment of premiums or fraud.
6. If you had been offered the option to continue under COBRA or a state continuation plan, you both elected and exhausted the continuation coverage.

If we have not yet met our enrollment quota, we will offer you the Ohio health care Basic or Standard benefit plans for purchase. You may need to submit proof of previous creditable coverage.

You are a **Non-Federally Eligible Individual** if you meet the following conditions:

1. You are not applying for coverage as an employee of an employer, member of an association or member of any other group.
2. You do not have any other health coverage and are not eligible to be covered under any private or public health benefit plans including the following:
  - a. Medicare or Medicare supplement policy
  - b. Medicaid
  - c. Any COBRA or state continuation coverage plan
  - d. Other health benefits arrangement

If we have not yet met our enrollment quota, we will offer you the Ohio health care Basic or Standard benefits plans for purchase. We are not required to accept applicants who, at the time of enrollment, are confined to a health care facility due to chronic illness or permanent injury. As a Non-Federally Eligible Individual, coverage may be limited for pre-existing conditions for the first 12 months, however, we will credit time you were covered under a recent previous health plan.