MEDICAL MUTUAL OF OHIO

Subscriber/Policyholder Agreement for List Bill Administration

Upon issuance of an Medical Mutual of Ohio individual health coverage policy, I ______________________________
(print name)

hereby give Medical Mutual permission to send a bill for my health coverage policy to my employer,

____ . I understand the bill for
(insert business name)

this policy will be sent to my employer for payroll deduction purposes and will include my name, social security number and the amount of my monthly premium.

By signing this form, I certify that I am applying for coverage through Medical Mutual that will be paid for through payroll deduction by my employer. I understand that the premium payments made through payroll deduction are only for my convenience and that I am not applying for a policy sponsored by my employer. I acknowledge and understand that my employer is not paying any of the premium, either directly or indirectly and that it is my responsibility to ensure that my premiums are paid in a timely manner. As part of this application I agree and understand that my dependents (if applicable) and I will be medically underwritten by Medical Mutual and must be accepted by Medical Mutual before the policy will be offered. I further understand the policy being issued is not an employer group health plan and is not intended to be an employer group health plan by my employer.

Signed ____ Date __________________________________

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