Employee Name	Group/Company Name
Social Security #	Group #/Section # (required)

Section VIII: TERMS AND CONDITIONS

1. I hereby apply to the COSE Health and Wellness Trust [(MEWA)]. I acknowledge that I am applying for an employee health benefit offered collectively through the MEWA under a certificate of authority issued by the Ohio Department of Insurance and that this benefit may be subject to special terms and conditions outlined by the MEWA Summary Plan Description and Plan Document as amended from time to time by the Greater Cleveland Partnership.

2. I understand that the dental and vision benefits made available through the MEWA are fully insured by Medical Mutual ("Medical Mutual"). I understand that the life, AD&D, disability fixed indemnity and accident-only benefits made available through the MEWA are fully insured by Consumers Life Insurance Company ("CLIC").

3. I authorize (1) payroll deduction(s) and remittance of any required contribution for coverage to the MEWA and/or any affiliates, contracted third party administrators, and representatives; (2) release of information, without limitation, from any medical/medically related facility, prior health insurance carrier, the Medical Information Bureau, Inc. (MIB), prescription history database supplier, government agency or person to the MEWA, its Plan Administrator, and Medical Mutual/CLIC and/or any affiliates, pharmacy benefit manager, third party administrator, reinsurance companies, agents and representatives; (a) to evaluate this Application; (b) to adjudicate claims submitted on behalf of me or my dependents; (c) for utilization review programs to monitor health services or quality improvement activities and/or; (d) for credentialing purposes. I authorize the MEWA, its Plan Administrator, and/or Medical Mutual/CLIC to provide a photocopy of this release to any physician or medical institution to obtain records for the purposes stated above. This authorization will be valid for a period of two and one-half years for the purpose of collecting information regarding this Application.

4. By signing below, I represent and warrant as follows: (a) I have thoroughly read and understand this Application and the questions asked herein; (b) I am solely and exclusively responsible for the truth, accuracy and completeness of all of the answers contained in this Application; (c) I have answered every Application question set forth in this Application; (d) all of my answers to each of the questions are accurate, complete and true; and (e) I did not sign a blank or partially completed Application.

5. I understand and agree that no agent or broker who may be assisting in the completion of this Application has any authority; (a) to waive any answer to any portion of any answer to any question on this Application or any information the MEWA, its Plan Administrator, and/or Medical Mutual/CLIC requests; (b) to advise me that I am not obligated to disclose any condition of which I am aware concerning my health or the health of any dependent included on the Application; (c) to make any representation concerning benefits that are inconsistent with, or different from, any written information provided by the MEWA or its Plan Administrator; (d) to bind the MEWA in any way by making any statement, promise or representation that is not set out in writing in this Application or regarding eligibility, benefits or coverage under a policy; (e) to answer any questions in, or insert any information on, this Application on my behalf; or (f) to approve my enrollment in the MEWA. All contract terms must be in writing and signed or accepted in writing by an authorized representative of the MEWA's Board of Trustees. The applicable certificate or evidence of coverage will determine the rights and responsibilities of covered person and will govern in the event they conflict with any benefit comparison summary or other description of the plan.

6. I understand and agree that I am responsible for disclosing all information required by this Application, including, but not limited to, all health conditions and diagnoses of which I am aware. I understand and agree that the MEWA, and its Plan Administrator, and/or Medical Mutual/CLIC have the exclusive right to determine whether a particular condition or diagnosis is significant, that I do not have the right to evaluate whether a condition or diagnosis should or should not be disclosed on this Application and that I am obligated to disclose even those conditions or diagnoses that I do not believe are significant or important.

7. I agree that any untrue or incomplete information, statement or answers on this Application can result in denial of a claim and that any intentional misrepresentation of material fact or fraud in this Application can result in rescission of coverage and may subject me to legal action by the MEWA and/or Medical Mutual/CLIC.

8. I understand that I must notify Medical Mutual , in writing, immediately if I (the applicant) or any other person for whom coverage is sought receives medical treatment, advice, care or a diagnosis for any illness, injury or condition after the date I sign this application but before my coverage approval date. I understand that in this situation, Medical Mutual has the right to underwrite my application again, using the new information and that, as a result , my coverage/family member's coverage might be rescinded or delayed or benefits denies due to the illness, injury or condition being treated as a preexisting condition.

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Employee Name	Group/Company Name
Social Security #	Group #/Section # (required)

Section VIII: TERMS AND CONDITIONS (continued)

9. To be eligible for coverage, I must be an active full-time employee as defined by the plan documents.

10. I understand that in order to be eligible for coverage through the MEWA, I must meet the eligibility requirements set forth in the plan documents of the MEWA and: 1) for coverage as an employee, I must be an active, full-time employee drawing a regular paycheck; and 2) for life, AD&D, disability, dental, vision, fixed indemnity and/or accident-only coverage, I must also meet the eligibility requirements of Medical Mutual/CLIC; to be eligible for such coverage, I must be an active full-time employee as defined by the group participation agreement.

11. My dependents and I understand and agree that any information obtained will not be released by the MEWA, its Plan Administrator, or Medical Mutual/CLIC to any person or organization except to reinsuring companies, the MIB, or other person or organizations performing health care operations or business or legal services in connection with any application, claim, or as may be otherwise lawfully required, or as we may further authorize. If a Consumer Reporting Agency is used, I (we) may request to be interviewed in connection with the preparation of the report. Once personal and health (including medical, dental and pharmacy) information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient, and the information may not be protected by federal and state privacy requirements. A copy of this authorization request is available to me or my legal representative upon request. A photographic copy of this authorization shall be valid as the original. This authorization shall be valid for a period of two and one-half years. I have the right to revoke this authorization at any time. To revoke this authorization, I must do so in writing and send my written revocation to the Offices of the MEWA's Board of Trustees. The revocation will not apply to information that has already been released in response to this authorization. The revocation may adversely affect my Application, a claim or a pending insurance action. The revocation will become effective after it is received by the MEWA's Board of Trustees. Your refusal to authorize release of information may impact your ability to enroll in the COSE MEWA if Medical Mutual needs this information to determine your eligibility for coverage.

12. I understand and acknowledge that this authorization extends to all medical records, including records which may contain information regarding treatment for physical and mental illness, alcohol/drug abuse and/or HIV-AIDS test results or diagnosis. I expressly consent to the release of such information.

13. If I am applying for coverage for my domestic partner, I represent and warrant that I and my domestic partner: 1) cohabit and reside together in the same residence and have done so for at least six months and intend to do so indefinitely; 2) are engaged in an exclusive and committed relationship and are financially interdependent; 3) are both at least 18 years of age and are each other's sole domestic partner; 4) are not married or separated from anyone else; 5) have not had another domestic partner within six months of establishing the current domestic partnership; 6) are not related by blood; and 7) are not in this relationship solely for the purpose of obtaining insurance benefits.

14. The MEWA for which I am applying is a self-insured plan, and benefits are not guaranteed by a licensed insurer. The MEWA is not covered by the Ohio Life and Health Guaranty Association. This is a fully assessable benefit plan. In the event that the multiple employer self-insured health plan is unable to pay its obligations, participating employers shall be required to contribute on a joint and several basis the funds necessary to meet any unpaid obligations. The Plan does provide certain protections to Plan Sponsors regarding this assessment. Certain other major protections offered to Ohio residents under the Ohio Insurance Code and Rules and Regulations, such as conversion rights and certain mandated or required benefits, may not be available through the multiple employer self-insured plan.

I am signing this Application on my own behalf and on behalf of all listed dependents. An unaltered copy of this authorization is as valid as the original. I have read all of the statements contained in this Application, and declare by signing this Application that I am an active, eligible, compensated, full-time employee and that the information I have provided is true and complete to the best of my knowledge. I understand that I should not cancel any current coverage until I receive an approval letter and certificate of coverage from the MEWA.

Employee Signature _____ Date _____

WARNING: Any person who, with intent to defraud or knowing that he is facilitating fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. (Ohio Revised Code Section 3999.21).