



Ohio Small-Group Benefit Change Request Form

Please fill out all of the information on the following lines. This form must be received by Medical Mutual two weeks prior to the requested effective date of change. This will not change your group anniversary/renewal date. New ID Cards and/or Certificates will go directly to the Group.

Group Name: _____

Medical Mutual Group Number: _____

Please list desired product choice(s) for the following coverages:

Medical:

Prescription:

Dental:

Vision:

Requested Effective Date of Change: ___/___/___ (MM/DD/YY).

I hereby authorize Medical Mutual of Ohio (MMO) to change my healthcare program as noted above. I understand that this request must be received by MMO prior to the requested effective date and is subject to underwriting regulations in effect and the final approval of MMO.

Authorized Group Signature: _____

Print Name: _____

Title: _____

Date: _____