Employer Group Enrollment/Change Form

☐ initial enrollment ☐ change

1. Group/Company Information

Business Name				
Has this business ever been known by another name? ☐ Yes ☐ No If yes, what name(s)?				Membership # (if applicable)
Business Address (No P.O. Boxes)			Billing Address	
City	County	State	Zip Code	Business Phone Number
Office Manager	Billing Contact			Business Fax Number
Business E-Mail	Number of years in business (If less than one year specify the date the business started.)			
Type of Business (be specific)	SIC Code/NAICS Code			Employer/Federal Tax ID #

Is the employer contribution at least 25% of each contract? ☐ Yes ☐ No

Do you have any affiliations with other companies or unions (include parent, subsidiary, joint venture, etc...) ?

☐ Yes ☐ No If yes, please describe. ______________________________

If yes, do any of these affiliates qualify as a single employer under subsection (b), (c), (m), or (o) of the Internal Revenue Code Section 414? If yes, please give the legal names, federal tax ID# and number of employees.

____

____

____

2. Enrollment Criteria

Eligible Employee Definition: What is the minimum # of hours to be worked per week for employees to be considered eligible for benefits*___________________

Probationary Period for New Hire Benefits

- ☐ Date of Hire
- ☐ First of month following Date of Hire
- ☐ 30 calendar days following Date of Hire
- ☐ First of month following 30 calendar days
- ☐ 60 calendar days following Date of Hire
- ☐ First of month following 60 calendar days
- ☐ 90 calendar days following Date of Hire

Probationary Period for Rehire ☐ same as above ☐ other_____________________

Waive probationary period for initial enrollment?
☐ Yes ☐ No

* Minimum must be within 20 – 30 hours per week, for full time eligibility for groups with 50 or fewer eligible employees.

Participation	Active**	COBRA	Retired**
Total number of current employees (part time & full time)			
Total number of eligible employees			
Number of eligible employees applying for coverage			
Total number of ineligible employees			
Total number of waivers			

**Including owners, officers and partners who receive compensation from the company, reported on a tax form other than a 1099.

Provide details below for anyone currently eligible or enrolled in COBRA.

Name	Social Security #	Beginning Date	Expiration Date	Qualifying Event

Provide details below for any retirees who meet the eligibility requirements AND are members of a formal retirement program?

Name	Social Security #	Age at Retrmnt	Date of Retrmnt	Date of Hire	Avg. Hrs. Worked Per Week Prior to Retrmnt

3. Products

Employers of more than twenty-five (25) employees may select up to three options.
Employers of more than ten (10) employees may select up to two options.
Employers of fewer than ten (10) employees may make one health plan election.

Health Plan Options

- ☐ $ 500/80%
- ☐ $1000/80%
- ☐ $2250/80%
- ☐ $5000/80%
- ☐ HSA $2500 Agg.
- ☐ HSA $3000
- ☐ HSA $4000
- ☐ HSA $5000
- ☐ HSA $7000
- ☐ Other

Dental Plan Options*

- ☐ Traditional Dental w/ortho
- ☐ SuperDental 186 (no ortho)

Vision Plan Option*

- ☐ Traditional Vision

*Insured through Medical Mutual of Ohio

4. Employer Funding

Is any part of the employee's or dependent's deductible being funded by the employer or from an employer-established account? ☐ Yes ☐ No If so, how much? Single: _________ Family: _________

Does the employer fund first? ☐ Yes ☐ No

5. Current and Prior Carrier History

List all carriers used for all product lines of insurance offered to the employees for the past 5 years. If there are no carriers, indicate NONE. (list current carrier first)

Carrier Name	Continuing Coverage	Benefits*	Dates		Current Rates**				Renewal Rates**			
			From	To	Emplye	Spouse	Child	Family	Emplye	Spouse	Child	Family
	☐											
	☐											
	☐											

*Examples: Traditional, PPO, HMO, Self Insured, etc...
**If you're age banded with current carrier, please provide most recent billing statement.

6. Validations

Has anyone within the past 24 months been hospitalized, institutionalized or missed work due to any disability or work related injury? ☐ Yes ☐ No If yes, provide details below.

Patient Name	Describe Illness or Condition

7. Life, AD&D, Dependent Life and Short-Term Disability*

*These benefits are underwritten and insured by Consumers Life Insurance Company.

☐ Yes I am electing life and/or short-term disability coverage in accordance with proposal number ________________________, incorporated by reference in and made part of this application for all purposes.
If multiple plans are indicated on the proposal, indicate plan option elected ____________________.

The requested effective date will be as stated in the above-mentioned proposal, unless indicated below:

__________________________________.

If the Company approves this application, a policy will be issued. The applicant agrees that acceptance of the Policy will be approval of the Policy terms.

Participation-free coverage
☐ Yes, I am electing participation-free Voluntary Life and AD&D
☐ Yes, I am electing participation-free Voluntary Life, AD&D and short-term disability.
If participation-free, voluntary short-term disability is elected, indicate the plan: _ 1/8/13 _ 1/8/26

Waiting period is identical to medical probationary period, unless indicated below:
☐ None
☐ First of month following completion of _____ days
☐ Other ____________________________________

Employees working less than 20 hours per week are not eligible for coverage. If different than 20 hours, please indicate number of hours:___________

Employer contribution percentages (%) for all products are stated in the proposal, unless indicated below:

Product	%	Product	%

Group Long-Term Disability

☐ Yes I am electing group long-term disability coverage in accordance with proposal number ________________________, incorporated by reference in and made part of this application for all purposes.
If multiple plans are indicated on the proposal, indicate plan option elected ____________________.

The requested effective date will be as stated in the above-mentioned proposal, unless indicated below:

__________________________________.

If the Company approves this application, a policy will be issued. The applicant agrees that acceptance of the Policy will be approval of the Policy terms.

Prior carrier: ____
(Prior carrier must be listed and a copy of the prior policy included for **continuity of coverage** to apply.)

Termination date of prior policy: ____

Waiting period – present employees: ____

Waiting period – future employees: ____

Employees working less than 30 hours per week are not eligible for coverage. If different than 30 hours, please indicate number of hours: _________ .

Contribution:
Employer _______% Employee _______% ☐ Pre-tax dollars ☐ Post-tax dollars

8. Terms and Conditions

I, as the undersigned employer and eligible organization duly organized under the laws of the state of Ohio, hereby apply to the Ohio State Medical Association Health Benefits Plan. I acknowledge that I am applying for an employee health benefit offered collectively through the Ohio State Medical Association Health Benefits Plan 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 Ohio State Medical Association Health Benefits Plan Summary Plan Description and Plan Document as amended from time to time by the Board of Trustees of the Ohio State Medical Association Health Benefits Plan.

I understand, acknowledge and agree to the following:

- Dental and vision benefits made available through the Ohio State Medical Association Health Benefits Plan are insured by Medical Mutual of Ohio ("Medical Mutual"). Life, AD&D and disability benefits made available through the Ohio State Medical Association Health Benefits Plan are insured by Consumers Life Insurance Company ("CLIC").
- This Employer Group Enrollment/Change Form ("Application") is not a contract for benefits. I should continue my current coverage until I am notified in writing that the Ohio State Medical Association Health Benefits Plan has accepted this Application.
- If this Application is accepted by the Ohio State Medical Association Health Benefits Plan, the actual benefits will be specified in the group participating agreement and that said benefits will take effect on the date specified in a communication from a representative of the Ohio State Medical Association Health Benefits Plan. If the Application is accepted by Medical Mutual/CLIC, the actual benefits will be set forth in the Group Policy, Summary Plan Descriptions and Certificates.
- For all groups, each employee not enrolling must complete the waiver section of the applicable employee application and each employee enrolling must complete all sections of the applicable employee application.
- To be eligible for coverage through the Ohio State Medical Association Health Benefits Plan, all participants must meet the eligibility requirements set forth in the plan documents of the Ohio State Medical Association Health Benefits Plan and: 1) for employee coverage, all employees must be active, full-time employees drawing a regular paycheck, whose compensation is reported on IRS Form W-2; and 2) for life, AD&D, disability, dental and/or vision coverage, all participants must also meet the eligibility requirements of Medical Mutual/CLIC.
- To be eligible for coverage, I must comply with all applicable laws of the State of Ohio. By applying for coverage, I agree that the Ohio State Medical Association Health Benefits Plan may, from time to time, verify my compliance with the underwriting, eligibility or participation standards of the pertinent program. I agree to provide payroll records if requested by a representative authorized by the Ohio State Medical Association Health Benefits Plan or Medical Mutual/CLIC.
- Any untrue or incomplete information, statements or answers on this Application (whether or not intentional) or engaging in any fraudulent conduct, deceptions or misrepresentation relating to any application, coverage, claim or usage of a Ohio State Medical Association Health Benefits Plan identification card, can result in denial of a claim or rescission of coverage for me or any group member, and may subject me or any group member to legal action by the Ohio State Medical Association Health Benefits Plan. I have a duty to notify the Ohio State Medical Association Health Benefits Plan of any changes to the information contained in this application.
- Approval and acceptance of this Application and individual employee applications are subject to underwriting guidelines as permitted by law. Checking boxes does not cause automatic enrollment. The Ohio State Medical Association Health Benefits Plan must approve this Application for health coverage, and Medical Mutual/CLIC must approve this Application for life, AD&D, disability, dental and vision coverage.
- By signing this Application, I represent that this group or company is not an entity that has been formed primarily to obtain benefits, and it does not permit membership in this group or company solely for the purpose of obtaining benefits.
- No agent or broker has the authority to: (1) bind the Ohio State Medical Association Health Benefits Plan by making promises regarding eligibility, benefits, or the issuance of coverage; (2) waive any answer or any portion of any answer to any question on this Application or any information the Ohio State Medical Association Health Benefits Plan requests; (3) approve coverage; (4) make or alter any contract on behalf of the Ohio State Medical Association Health Benefits Plan; or (5) waive or alter any of the Ohio State Medical Association Health Benefits Plan rights or requirements.

9. Authorized Signature (Please print)

All contract terms must be in writing and signed or accepted in writing by an authorized representative of the Ohio State Medical Association Health Benefits Plan.

Business Name	Name (print)	Title
Authorized Signature		Date
Broker Signature (if applicable)	Broker Name (print) (if applicable)	
Commissions Payable to Federal Tax ID #	Royal Advantage Broker	

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