

OSMA HBP
New Business Case Submission Checklist

Group Name _____

Broker / Agency Name _____

- Employer Application
- Employee Enrollment & Waiver Applications Through Form Fire
(Eligible employees & dependents enrolling or waiving health coverage must complete a Form Fire application)
Group Size _____ Applying _____ Waiving _____
- Copy of Sold Plan(s) Tier & Rates
If group is selecting multiple plans, please provide a detailed list of each employee and their plan selection.
- Health Binder Check – **Payable to OSMA HBP Trust** \$ _____
- Ancillary Binder Check – Payable to Medical Mutual \$ _____
Dental _____ Vision _____ Life(amount) _____
- Reconciled Wage & Tax Form
- Reconciled Form Fire Census
- Deductible Credit Carryover Form (if applicable)
- Signed Participation Agreement & Adoption Addendum
- 60 Day Notice of Plan Change from Employer (on company letterhead)
- Medicare Primary Registration Form (if group has 65+ year old working employee(s) and less than 15 FTE's)
- Annual Rate and Census (ARC) Confirmation (if group has 65+ year old working employee(s) and less than 15 FTE's)
- Current OSMA Member Name _____
If not a current member, provide a contact name _____ and email address _____ where membership information can be sent.

Effective dates are the 1st of the month only.



OSMA Insurance Agency
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Working to Keep Your Practice Independent



OSMAHBPSCCL 1015