ODA Wellness Trust

Health Plan Participation Request/Contract

Administered by: Medical Mutual

Send forms to: Ohio Dental Association Services Corporation
1370 Dublin Rd, Columbus, OH 43215
Phone: 614-486-2700
Fax: 614-340-9444

Please Print

Section 1: Employer Information

Employer Name: _____

ODAWT Group #_____

Federal Tax Identification #: _____

Address: _____
Street Address City State Zip

Phone:( ) _____ Fax: ( ) _____ E-Mail Address: _____
REQUIRED

Section 2: Billing Information

Billing Address (if different from above): Phone:( ) _____ Fax: ( ) _____

_____
Street Address Suite City State Zip

Billing Contact Name: _____ SIC: 8021

Section 3: Enrollment Criteria

What is the minimum # of hours to be worked per week for employees to be considered eligible for health benefits*
_____ **minimum 25 hours, maximum 30 hrs*

Waiting period for newly hired eligible employees:
(Per ACA guidelines, may not exceed 90 calendar days. Eligible employees electing coverage shall be enrolled within the 60 day administrative period following their eligibility date.)

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

Employer Contributions (Check box and specify amount*)	Single	2-Person	Family	None
	☐ _____	☐ _____	☐ _____	☐ _____

* Please state in % or $ amount. **No contribution is required.**

Participation:

Total of employees applying and waiving must equal total number of eligible full-time employees – **INCLUDES DENTIST(S)**

Please complete office census on page 2.

Total number of current employees *(part time & full time)*	
Total number of eligible full-time employees:	
Number of eligible employees applying for new coverage:	
Total number of employees waiving: *Have you kept signed waivers on file? YES or NO*	

To apply for coverage, eligible employees complete a Personal Health Questionnaire to request a quote.
Eligible employees not applying need to complete a waiver.

Please list ALL Dentists and employees in your office on the below census or use additional sheet if necessary:

Title	First	MI	Last	Date of Hire	Hours per week	Quote/Waive Circle one	Email Address
						Q W	
						Q W	
						Q W	
						Q W	
						Q W	
						Q W	
						Q W	
						Q W	
						Q W	
						Q W	

Section 4: Billing & Collections Guidelines

Although the contract period is one year (except as provided in Section 7), payment of Health Care Fees will be required monthly. The following guidelines will be used for the Billing and Collection of the Health Care Fee:

1. *Bills will be mailed out on or about the 15th of the month prior to the billing month.*
2. *Remittance will be due on the 1st of every month.*
3. *If payment is not received, or moneys are not available for debit from a bank account by the end of the 31-day grace period, all coverage for a Participating Group's covered employees will be terminated retroactive back to the 1st of the month for which payment was due and the Participating Group will be responsible for Health Care Fees due until the earlier of the end of the contract period or by providing the Trust with the proper termination notice as provided for in Section 6.*
4. *Reinstatement will not be permissible for a Participating Group until one year from the date of termination.*
6. *Employee and/or dependent terminations must be sent to the Plan Administrator prior to the termination date. If a termination request is received more than 15 days after the termination date, the employee and/or dependent(s) will not be terminated until the end of the month in which the termination is received and the employer will be responsible for any applicable Health Care Fees for that month.*
7. *Billing will be based on the current census of employees enrolled in the system as of the date bills are run. Rates may change based on the individual age of each employee at the time of renewal.*

By signing this contract, the applicant understands that failure to pay Health Care Fees in accordance with the "Billing and Collections Guidelines" will result in the termination of this contract and that Group will be responsible for Health Care Fees due.

Section 5: Effective Date of Coverage

Effective Date of Coverage: _____

Please note the date that the applicant wishes coverage to start for eligible employees. This date is contingent upon acceptance of this Participation Request/Contract by the Trust. The applicant will be notified of the acceptance of this request and effective date in writing.

Section 6: Contract Terms & Termination of Contract

Contract Terms: The Renewal Date for this Plan is January 1st of each year. Renewal Rates will be provided at least 30 days prior to the Renewal Date. If accepted upon renewal, coverage will be renewed for additional one-year (1) contract periods (Renewal Contract Periods) by payment of the applicable Renewal Health Care Fees due at the Renewal Date. Renewals will be on the same terms and conditions as those in effect for the Initial Contract Period, unless notified otherwise by the Plan.

Termination of Contract: Participating Member's may terminate this Contract upon renewal by providing the Plan Administrator written notice within 15 days from the end of a Renewal Contract Period. Participating Member's may also terminate this Contract at any time by giving the Plan Administrator written notice at least 30 days in advance of termination date. Posted dated terminations are never allowed.

By signing this contract, the applicant agrees to pay the Health Care Fees as outlined in the attached proposal, as provided in Section 6, based on the census maintained by the Plan Administer for employees that are eligible for coverage under the benefit plan applied for through the end of the Initial Contract Period and, upon payment of revised Health Care Fees, any Renewal Contract Period. The applicant understands that each Renewal Contract Period will be for additional periods of twelve (12) months and at the Health Care Fees provided by the Trust 30 days prior to the end of each contract period, subject to change as described above.

Section 7: Summary of Benefits and Coverage (SBC)

The Patient Protection and Affordable Care Act has established many new requirements and standards for group health plans, including the requirement to create and distribute a uniform Summary of Benefits and Coverage (SBC). The purpose of the SBC is to provide standard information and uniform language across the health benefits business to allow consumers to easily compare options and select health plans. Members can access SBC's by visiting www.odawt.org. Copies of the SBC are available at www.odawt.org or upon request. Please call the Plan at (800) 282-1526 for a copy or if you have any questions about the SBCs. For more information regarding this healthcare reform provision, please visit www.healthcare.gov

Section 8: Underwriting Guidelines

Underwriting Guidelines are in force from the Effective Date of this contract and remain in effect for each subsequent Renewal Contract Period unless written notification is provided by the Trust. By signing this contract, the applicant agrees to the underwriting guidelines and proposal qualifications and understands that should it provide false information or fail to meet the requirements for eligibility, that it will result in the termination of this contract for all covered persons.

Section 9: Statement of Contingent Liability

The Plan is a self-insured plan, and benefits are not guaranteed by a licensed insurer. The Plan 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. 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. The applicant requests participation for its employees in the Trust.

Section 10: Participation Request

The applicant also agrees to be bound by all the conditions of participation and further agrees that:

1. *Neither this request to participate, nor the payment of any moneys to be applied towards contributions for coverage, shall cause coverage to become effective on any of the applicant's employees. In order for coverage to go into effect on the date specified by this Contract, the applicant must be accepted as a Participating Member and the applicant's employees must satisfy the applicable eligibility requirements.*
2. *If applicable, the applicant must be a member in good standing with its association when applying for participation in this Trust, must meet membership requirements established by the by-laws of its association and must remain a member in good standing with its association for coverage to stay in effect.*
3. *The applicant has seen a copy of the benefits proposed and agrees to pay the required contributions (Health Care Fees) to the Trust when due and in accordance with the Billing & Collections Guidelines. The Applicant further agrees to give all eligible employees an opportunity to enroll for coverage, if contributions from employees are required.*
4. *The coverage is subject at all times to the benefit plan applied for, which alone constitutes the contract under which benefits become payable.*
5. *I understand that should my employee(s) intentionally misrepresent a material fact or my failure to report information about my employees may be used as the basis to rescind, terminate or modify the entire group's coverage or coverage for a particular employee. Rescind means that the coverage was never in effect.*

Acceptance of this request is subject to all of the Trusts requirements, including the provisions of any Administrative Services Agreement between the Trust and any third party administrator, but only to the extent such provisions apply to rights and/or obligations applicable to employers accepted as Participating Employers in the Trust, and the terms of the applicable benefit plan. The Trust will notify the applicant of the approval or disapproval of this request. A notice of approval will specify the effective date of the applicant's participation in the Trust. If the applicant is accepted as a Participating Employer, it will receive the appropriate benefit plan descriptions and material for enrolling its employees.

The applicant hereby requests participation in the Trust and agrees to be bound by its terms and conditions and the terms and conditions of the Administrative Services Agreement mentioned in the prior paragraph (to the extent they apply to Participating Employers).

Name of Applicant (Please Print): _____

Signed: _____ **Date**:_____

FRAUD STATEMENT – Any person with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Section 11: To be filled out by Trust (Plan Sponsor)

☐ Applicant has been Accepted and has met all participation requirements. Coverage will become effective as to applicant's eligible employees on _____,_____.

☐ Applicant has been Declined and has not met one or all of the participation requirements.

Signed: _____ **Date**:_____

Authorized Representative of the Trust