OSMA Health – Health Services
13439 Broadway Extension Suite 110
Oklahoma City, OK 73114
Ph: (888) 244-5096 Fax: (405) 775-5991

65 Plus Enrollment Form

Last Name	First	MI	Date of Birth	Gender	Social Security Number

Address	Apt No.	City	State	Zip Code

Home Telephone	Work Telephone	Extension	E-mail address

1) Are you a: ☐ **Physician or Physician's Spouse** ☐ **Former Employee**

2) Are you actively employed or retired? ☐ **Employed (works 1 or more hours)**

☐ **Retired (does not work in any capacity)**

If employed, please provide the name of the employer and phone number _____

If employed, how many average hours per week do you work? _____ Hours per week.

3) Which Employer Group did you receive your OSMA coverage through? _____

a. Do you work 1 or more hours per week for that employer? ☐ **Yes** ☐ **No**

4) Are you now covered by Medicare? ☐ **Yes** ☐ **No**

If yes, what is the Medicare ID number shown on your Medicare card? _____

Please include a copy of your Medicare ID card.

5) Are you enrolled in Medicare Part B? ☐ **Yes** ☐ **No**

6) What is your Medicare effective date? **Part A** _____ **Part B** _____

7) Do you have another Medicare supplement or other health insurance policy or certificate in force? ☐ **Yes** ☐ **No**

If yes, please provide the name of the company, policy number and amount of coverage. Please include HMO and health care service contracts.

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Contribution Statement: Each Member must remit to OSMA Health (the Plan) the required contributions. All contributions must be paid on or before the first day of the period for which they are due. A 31-day grace period will be granted. Benefit payments may be suspended at the discretion of the Plan Administrator during the grace period. If payment is not made during the 31-day grace period, the Member's participation will be terminated and coverage cancelled retroactive to the date for which contributions were last paid. If any claims are paid for a non-covered period as the result of the Member's failure to make timely contributions, the Plan will recover such payments from the Member. A Member will not be considered for reinstatement until such amounts are recovered by the Plan.

Member Acknowledgement: I certify that information on this form and any attachments is true and complete at the time of completion. This form is a request for rates and information from OSMA Health. Any material misrepresentation or fraud on the part of the Member making application can at the discretion of the Plan result in immediate termination or rescission of coverage. Any disclosure of protected health information is done only for the express purpose of evaluating this application as permitted by state and federal law and all information is strictly confidential.

I understand OSMA Health is a Multiple Employer Welfare Arrangement (MEWA) licensed by the State of Oklahoma and subject to State and Federal Regulation. Benefits are self-funded and paid from the contributions of the participating employers and retirees. OSMA Health is not insurance and does not participate in any guarantee fund. The Plan Sponsor is OSMA Health and Welfare Benefit Corporation, a wholly-owned subsidiary of the Oklahoma State Medical Association. I understand that I must be a member of the Oklahoma State Medical Association to be eligible for coverage under the OSMA Health program. I further understand that the Plan is governed by the rules as noted in the Plan Document, Trust Document, and the By-Laws of the OSMA Health and Welfare Benefit Corporation.

Participant Signature **Date**