OSMA HEALTH Employer Application

Important: All information must be completed and all requested attachments submitted for OSMA Health to process your application.

Employer Name:	**Federal Tax ID Number:**	
Address:	**HR Contact:**	
City, State, Zip:	**Phone:**	**Fax:**
	Email Address:	
Corporate Officers/Owners:	**Billing Contact:**	
Name:	**Phone:**	**Fax:**
Name:	**Email Address:**	

1) Requested effective date for OSMA Health coverage _____
Renewal Cycle: ☐ Calendar Year (Jan 1st) or ☐ Contract Year (anniversary of effective date) -- Applies to 2+ life groups

2) Employer waiting period for coverage: ☐ 0 Days ☐ 30 Days ☐ 60 Days
After waiting period, coverage is effective: ☐ Immediately ☐ First day of the next month

3) Will this plan be offered to all eligible employees? ☐ Yes ☐ No
A signed **Declination of Coverage Statement** will be required from those declining coverage

4) Total number of employees: _____ Full time; _____ Part-time (those working less than 24 hrs/wk)
Number of employees covered under health plan _____
Please include a copy of your most recent Oklahoma Employer's Quarterly Contribution Report (Form OES-3)

5) Is your group subject to COBRA? ☐ Yes ☐ No
(requires 20 or more total employees during at least 50% of working days in the previous calendar year)

6) Do you presently provide group health benefits under another plan or company? ☐ Yes ☐ No
If Yes, please provide a copy of last month's billing statement. Date coverage will terminate _____

7) Do you have employees disabled or not actively at work? ☐ Yes ☐ No
If Yes, provide name(s) _____

8) Do you have former employees currently covered under COBRA? ☐ Yes ☐ No
If Yes, provide name(s) _____

9) Do you lease your employees or are you currently a client company of a Professional Employer Organization (PEO)?
☐ Yes ☐ No

Medical Coverage Selected*

PPO Plans	Qualified High Deductible Health Plans (HDHP)
☐ Essential PPO $1,000	☐ HDHP $3,000/$6,000
☐ Advantage PPO $2,000	☐ HDHP Choice $5,000/$10,000
☐ Preferred PPO $4,000	

***Maximum of 2 plans allowed: 1 PPO Plan and 1 HDHP Plan**

Billing Options:
Groups of 1: ☐ Bank Draft* ☐ Quarterly ☐ Semi-Annually ☐ Annually
Groups of 2 or more: ☐ Bank Draft* ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

If electing Bank Draft, please provide the following:
Name on Account: _____ **Bank Name:** _____
Bank Routing Number: _____ **Account Number:** _____
***Please include a voided check.**

Contribution Statement: I agree to pay to the Plan, in advance, the premiums specified in the Group Billing Statement on behalf of each Eligible Person covered under the Group Contract.

Employer Acknowledgement: I acknowledge it is the responsibility of the Participating Employer, and not the Third party Administrator, to comply with COBRA and all other Federal mandates pursuant to the Internal Revenue Code and hold the OSMA and the Third Party Administrator harmless for any non-compliance.

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, wholly-owned subsidiary of the Oklahoma State Medical Association. I understand that 50% of the owners/physicians must be members of the Oklahoma State Medical Association for our group to be eligible for coverage under the OSMA Health program and that our group must comply with all participation requirements of the health plan. I further understand that the Plan is governed by the rules as noted in the Policy and the By-Laws of the Oklahoma State Medical Association.

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 (the Plan). Any material misrepresentation or fraud on the part of the Employer making application can at the discretion of the Plan result in immediate termination or rescission of coverage.

I authorize the Plan to contact any of my employees to obtain a release for the purpose of developing additional medical information about prospective plan participants as may be necessary to evaluate the Employer's application. 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.

Employer Authorized Signature	Title		Date
Broker Printed Name	**Broker Signature**	**Broker Number**	**Date**