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

OSMA HEALTH
people you know, coverage you can trust.

Enrollment Form / Change Form

EMPLOYER USE ONLY	EMPLOYER NAME	EFFECTIVE DATE	EMPLOYMENT DATE	GROUP NUMBER

SECTION 1—ENROLLMENT

OFFICE USE ONLY	MEMBER IDENTIFICATION NUMBER

☐ NEW ENROLLEE ☐ ADD DEPENDENT ☐ OPEN ENROLLMENT

☐ SPECIAL ENROLLMENT EVENT – DATE OF EVENT _____
☐ MARRIAGE ☐ BIRTH ☐ ADOPTION
☐ LOSS OF COVERAGE ☐ COURT ORDER

☐ DECLINATION OF COVERAGE

☐ NAME CHANGE/ADDRESS CHANGE (List in Section 3)

☐ COBRA START DATE_____ END DATE _____

☐ CANCEL EMPLOYEE ☐ CANCEL DEPENDENT (List dependent in Section 3)

☐ REASON FOR CANCELLATION: DATE OF EVENT _____
☐ TERMINATION OF EMPLOYMENT
☐ DIVORCE ☐ DEATH
☐ OTHER _____

DATE OF QUALIFYING EVENT_____

SECTION 2—PARTICIPANT TYPE AND PLAN SELECTION

Please check the appropriate participant type:

☐ Employee ☐ Employer/Owner OSMA Membership Date _____ Occupation_____ Do you receive a ☐ 1099 or ☐ W-2 ?

COVERAGE TYPE
- ☐ Employee Only
- ☐ Employee + Spouse
- ☐ Employee + Child/Children
- ☐ Family

MEDICAL PLAN SELECTION
- ☐ Essential PPO $1,000
- ☐ Advantage PPO $2,000
- ☐ HDHP Single $3,000*
- ☐ HDHP Choice Single $5,000*
- ☐ HDHP Family $6,000*
- ☐ HDHP Choice Family $10,000*
- ☐ PPO Plus
- ☐ Preferred PPO $4,000

***A SEPARATE ENROLLMENT FORM IS NEEDED TO OPEN AN HSA**

DELTA DENTAL
☐ Delta Dental – Complete Delta Application or visit website: www.deltadentalok.org/client/osma/

SECTION 3 – APPLICANT/DEPENDENT INFORMATION

Last Name **First** **MI** **Date of Birth** **Gender** **Height** **Weight** **Social Security Number**

Address **Apt No.** **City** **State** **Zip Code**

Home Telephone **Work Telephone** **Email Address** **Hours worked per week**

(List your dependents below only if you are enrolling, adding or removing coverage. Attach additional sheets if necessary.)

ADD	REMOVE	SPOUSE						
☐	☐	**Spouse's Full Name**	Date of Marriage		Date of Birth	Height	Weight	Social Security Number
		Employed By	Covered by other Insurance? ☐ Yes ☐ No		If Yes, Name of Plan			
		DEPENDENTS						
☐	☐	**Dependent's Full Name**	Relationship	Gender	Date of Birth	Height	Weight	Social Security Number
		Different Address? Yes ☐ No ☐ If yes, please provide: Street and Number			City, State, and Zip Code			
☐	☐	**Dependent's Full Name**	Relationship	Gender	Date of Birth	Height	Weight	Social Security Number
		Different Address? Yes ☐ No ☐ If yes, please provide: Street and Number			City, State, and Zip Code			

SECTION 3 – APPLICANT/DEPENDENT INFORMATION continued

Are any of the dependents that are listed on the previous page employed? ☐ Yes ☐ No
Are any dependents eligible for Other Insurance coverage? ☐ Yes ☐ No
If Yes, please list Dependent and provide name(s) of other insurance plan(s):

SECTION 4 – PRIOR HEALTH INSURANCE INFORMATION/OTHER INSURANCE INFORMATION

Within the last 12 months, have you, your spouse, or any dependents had any other health coverage? ☐ Yes ☐ No
If Yes, please provide the following information:
Name of Prior Health Insurance Company _____
Effective Date of Coverage_____ Termination Date _____
Who was covered under prior plan? ☐ Employee ☐ Employee & Spouse ☐ Employee & Children ☐ Family
*Will prior coverage continue if OSMA Health coverage is approved? ☐ Yes ☐ No
***Please include a copy of the front and back of your ID card with this application.**

Medicare – Employee Information:

☐ Enrolled in Part A: Effective Date _____	☐ Ineligible for Part A*	☐ Not Enrolled in Part A (chose not to enroll)**
☐ Enrolled in Part B: Effective Date _____	☐ Ineligible for Part B*	☐ Not Enrolled in Part B (chose not to enroll)**
☐ Enrolled in Part D: Effective Date _____	☐ Ineligible for Part D*	☐ Not Enrolled in Part D (chose not to enroll)**
Reason for Medicare eligibility: ☐ Over age 65	☐ Kidney Disease	☐ Disabled ☐ Disabled but actively at work
		Are you receiving Social Security Disability Insurance? ☐ Yes ☐ No Start Date _____

Medicare – Spouse/Dependent Name: _____

☐ Enrolled in Part A: Effective Date _____	☐ Ineligible for Part A*	☐ Not Enrolled in Part A (chose not to enroll)**
☐ Enrolled in Part B: Effective Date _____	☐ Ineligible for Part B*	☐ Not Enrolled in Part B (chose not to enroll)**
☐ Enrolled in Part D: Effective Date _____	☐ Ineligible for Part D*	☐ Not Enrolled in Part D (chose not to enroll)**
Reason for Medicare eligibility: ☐ Over age 65	☐ Kidney Disease	☐ Disabled ☐ Disabled but actively at work

If anyone is enrolled in Medicare, please include a copy of the Medicare ID card with this application.
*Check "Ineligible" only if you have received documentation from the Social Security Administration that indicates you are not eligible for Medicare.
**If you are eligible for Medicare on a primary basis (Medicare pays before benefits under the group policy), you should enroll in and maintain coverage under Medicare Part A, Part B, and/or Part D as applicable.

SECTION 5 – STATEMENT OF HEALTH Answer for each person applying for coverage

1. Within the past five years, has anyone consulted or received treatment by a doctor, psychiatrist, psychologist, or other practitioner or been diagnosed with any of the following conditions or disorders? ☐ Yes ☐ No

a	☐ AIDS or HIV	k	☐ Paralysis/Paresis	u	☐ Birth Defects/Congenital Abnormalities
b	☐ Diabetes	l	☐ Tumor/Cyst/Growth	v	☐ Arthritis/Bone/Joint/Muscle/Prosthetic Device
c	☐ Infertility	m	☐ Systemic or Discoid Lupus	w	☐ Mental/Nervous/Emotional/Eating Disorder
d	☐ Endocrine/Metabolic	n	☐ Lung or Respiratory	x	☐ Stroke/Brain/Neurological
e	☐ Pancreas	o	☐ Alcohol or Drug Use	y	☐ Organ Transplant
f	☐ Liver/Hepatitis	p	☐ Kidney/Bladder/Urinary	z	☐ Blood Pressure Disorder
g	☐ Immune System	q	☐ Circulatory/Vascular	aa	☐ Advised to have surgery or treatment not yet determined
h	☐ Blood Disorder	r	☐ Digestive/Stomach/Intestinal	bb	☐ Cancer: Type Stage
i	☐ Epilepsy/Seizure	s	☐ Central Nervous System		☐ Surgery ☐ Radiation ☐ Chemotherapy
j	☐ Heart	t	☐ Pituitary/Adrenal/Growth Disorder	cc	☐ Other

2. Is any female currently pregnant? If so, provide due date: ☐ Yes ☐ No
☐ C section planned ☐ Multiple Births Expected (#) ☐ Complications: ☐ Past ☐ Present
3. Has anyone been hospitalized in the past 24 months? ☐ Yes ☐ No
4. Has anyone applying for coverage been prescribed medications in the past 12 months? ☐ Yes ☐ No
5. Does anyone applying for coverage have a known condition that requires on-going treatment? ☐ Yes ☐ No
6. Do you or your dependents use tobacco products? If yes, check the applicable boxes: ☐ Yes ☐ No

☐ Employee	☐ Cigarettes	☐ Pipe	☐ Cigars	☐ Chewing Tobacco
☐ Dependents	☐ Cigarettes	☐ Pipe	☐ Cigars	☐ Chewing Tobacco

SECTION 5 – STATEMENT OF HEALTH continued

Provide details below to any boxes checked on the Health Statement on page two. If additional space is needed, attach a separate sheet and sign and date sheet.

Question Number	Name of Individual	Condition/Diagnosis	Onset Date	Date Treatment Ended	Names of Prescription Medication	Dosage	Still Taking Medication
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No

SECTION 6 – DECLINATION OF COVERAGE STATEMENT

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

I have been offered the benefits of the OSMA Health Plan, but I elect not to be covered under the plan for the following reason:

☐ I have coverage through my spouse. ☐ I have coverage through Medicare. ☐ I have coverage through an individual policy.
☐ I do not want coverage. ☐ Other_____

Employee Signature (if declining coverage) Date **Employer Verification/Authorized Signature Date**

SECTION 7 – AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize any physician, medical practitioner, hospital, clinic, Veteran's Administration facility, other medical or medically-related facility, insurance or reinsuring company, the Medical Information Bureau, Inc., or Consumer Reporting Agency having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or my dependents and any other non-medical information of me or my dependents to give to the Plan or their legal representative any and all such information. **I understand that such information may include information about infectious, communicable or contagious diseases, which may include, but not be limited to, diseases such as Hepatitis, Syphilis, Gonorrhea or the Human Immunodeficiency Virus also known as Acquired Immune Deficiency Syndrome (AIDS).** I understand the information obtained by use of the authorization will be used by the Plan to determine eligibility for Insurance and eligibility for benefits under an existing Plan. Any information obtained will not be released by the Plan to any person or organization except to reinsuring companies, the Medical Information Bureau, Inc., or other persons or organizations performing business or legal services in connection with my application or claim or as may be otherwise lawfully required or as I may further authorize. I know that I may request to receive a copy of this authorization. I agree that a photographic copy of this authorization shall be as valid as the original. I agree that this authorization shall be valid until the Plan receives a written request for revocation.

I understand that coverage will not become effective until approved:

Employee Signature Date **Employer Verification/Authorized Signature Date**