ODA WELLNESS TRUST
ODA MEMBER BENEFIT

1370 Dublin Rd
Columbus OH 43215
Phone: 614-486-2700
Fax: 614-340-9444

CONFIRMATION OF COVERAGE SELECTION

Office Name: _____ Group # or New :_____

Employee Name	**Plan Name and Deductible** (see chart below)	**Coverage** (EE, EE+Sp, EE+Ch, EE+F)	**Monthly Cost** (see rate quote)

Plan Name:	**SMP**	**SMP HDHP**	**HSA Single**	**HSA Two Person or Family**	**SMP HDHP – 3**
Deductible Selection:	$250	$2,000	$2,000	$4,000	$3,500
	$500		$3,000	$6,000	$6,500
	$750				
	$1,000				

Plan Summary and SBCs available at: https://www.odawt.org/odawt-plans/compare-plans/

Effective Date of Coverage: _____

Employer Signature: _____ Date: _____

By my signature above, I represent that all information on this application is correct. I understand that the benefits selected will be in effect for this plan year and cannot be changed unless there is a qualifying life event as defined by the IRS.

FRAUD STATEMENT – Any person with intent to defraud or knowledge 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.

(Please review and keep for your records)

OHIO DENTAL ASSOCIATION WELLNESS TRUST AGREEMENT
ADDENDUM

I. **Effective Date of Coverage: January 1, 2024.**
The effective date represents the start date of plan coverage for eligible employees. This date is contingent upon acceptance of this Addendum.

II. **Health Care Fees**

A. Health Care Fee Final Quote (rates) is effective from the Effective Date of Coverage for 12 months (Initial Contract Period). The Plan reserves the right to adjust rates during the contract period should the claim expenses or plan utilization exceed projections.

III. **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.

Contract Terms: Renewal Rates will be provided at least 30 days prior to the next Renewal Date. If accepted upon renewal, coverage will be renewed for an additional one-year contract period (Renewal Contract Period) 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 ODAWT written notice within 15 days from the end of the Renewal Contract Period.
Participating Member's may also terminate this Contract at any time by giving the ODAWT written notice at least 30 days in advance of termination date. If written notice is not provided 30 days in advance the Participating Member will be responsible for Health Care Fees that would be due as if proper notice had been provided, i.e. for the 30 day period. Postdated terminations are never allowed.

IV. By signing this contract, the applicant agrees to pay the Health Care Fees as outlined in the renewal proposal. The applicant understands that each Renewal Contract Period will be for an additional period of twelve (12) months and at the Health Care Fees provided by the Trust 30 days prior to the end of each contract period.

By:_____ Authorized Signature of Employer
_____ Print Name