Administered by: MEDICAL MUTUAL

ODA Wellness Trust

Health Plan Participation Request

Please Print

Send forms to:
Greater Cleveland Dental Society
200 Treeworth Boulevard, Cleveland, OH 44147
Phone: 440-717-1891
Fax: 440-627-6711

Section 1: Employer Information

Employer Name: _____

ODAWT Group #_____

Federal Tax Identification #: _____

Office Address: _____

Street Address City State Zip

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

REQUIRED

Section 2: Billing Information

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

_____

Street Address City State Zip

Billing Contact Name: _____ SIC: 8021

Email Address: _____

Section 3: Participation Criteria

Please read this summary of Participation Criteria carefully, it is very important that you understand the requirements and that if they are not followed, your group's participation in the Trust can be cancelled by the ODAWT after 30 days' notice.

Groups must meet all of the following requirements to be considered eligible.

- A legal entity and member is in good standing with the Ohio Dental Association engaged in full-time practice where an employer/employee relationship exists.
- 65% of net eligible are covered. "Net eligible" is the number remaining after removing any excluded employees as described below*.
- A minimum of 2 employees must be enrolled to be considered an eligible group.

*Excluded employees are those who waive coverage because they:

- Have coverage through a spouse's employer plan;
- Are covered under a parent's plan;
- Are enrolled in Medicare;
- Are enrolled in Medicaid or another government-sponsored plan;
- Are enrolled in an individual plan purchased on the Exchange and qualifies for a federal subsidy.

Also complete the following:

- Health Plan Participant Form – included
- ODAWT Plan Participation Details and Table 2
- Personal Health Questionnaire's for all eligible employees applying
- Waiver Table 3 with signatures for all eligible employees not applying

Section 4: 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.

ODA Wellness Trust

Administered by: Medical Mutual

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Phone: 440-717-1891
Fax: 440-627-6711

ODA Wellness Trust Plan Participation Details

Employer Information:

Group Name:	ODA Member Name:
Federal Tax Identification #:	

Participation 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 hours*

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 employer contribution is required.**

	Table 1: Calculating Participation Requirements (Information to complete this table is found in Table 2 on Page 2)		
1	Total number of current Employees (*part-time & full-time*) including Doctors:		
2	Total number of Eligible Full-time Employees (Tables 2 & 3, Column A):		
3	Number of Eligible Employees currently enrolled or requesting a quote (Table 2):		
4	Total number of Eligible Employees with **Qualified Waivers**: Covered through Parent, Spouse's Employer, Subsidy, Medicaid, or Medicare (Table 3, Column B)		
5	Total number of Eligible Employees waiving due to Individual Coverage or No Coverage: (Table 3, Column B)		
	Participation Requirement: 65% of net Eligible Employees, Minimum of 2 Subscribers per Group. (Line **2** –Line **4**) = Total Eligible Employees **x 65%** ≥ 2 *Please contact ODAWT at 1-800-282-1526 with questions regarding final Participation Calculation.*		

Table 2: ODA Wellness Trust Participation

Please list below **ALL** Doctors and Employees in your office that are:

(use additional sheets if necessary)

1. **Currently** enrolled in ODAWT
2. Requesting an ODAWT **Quote**
3. Part-Time or **Not** Eligible*:

Group Name:					**Column A**	
Title: **Dr, Mr, Ms**	First Name	MI	Last Name	Date of Hire	Total Hours Per Week	Indicate: **C-** Current ODAWT **Q –** Eligible **N –** Not Eligible*

*Ineligible employees include: part time employees that work less than 25 hours per week, temporary employees, or employees that have not completed the group probationary period.

Table 3: ODA Wellness Trust -- Waivers
Please list ALL Doctors and Employees in your office on the below census that are ***waiving coverage***: (use additional sheets if necessary)

Group Name:

Employer Signature: | **Date:**

				Column A	**Column B**	**Column C**	
Title **Dr, Mr, Ms**	First Name	Last Name	Date of Hire	Total Hours Per Week	If Waiving Coverage, indicate why: **S** = Spouse' Employer **P**= Parent **Sub**= Subsidy **M**= Medicare or Medicaid **No**=No coverage **IND** = Individual coverage	**Waiver **** Please complete information below and sign. If no other coverage, indicate N/A and sign.	
						Plan Name **And** Company/Group Sponsor	Signature

**This benefit waiver is available to employees who are regularly scheduled to work the minimum number of hours per week as specified in the Employer Health Plan Participation Request/Contract on file with the ODA Wellness Trust. Upon renewal of the Group Health Plan, employees may elect to continue to waive out or enroll in the benefit program during the open enrollment period, or at any time upon a qualifying event as defined in the Plan's Summary Plan Description.

I voluntarily agree to waive coverage under the health benefits offered by my Employer.

I understand the above explanation of my rights to waive benefits or enroll in the benefit program offered. I understand that if I purchase individual health insurance, it must not be paid for with pre-tax dollars, and any contribution from my employer toward individual health insurance will be considered part of my salary and taxed as such.