OHIO HARNESS HORSEMEN'S HEALTH INSURANCE TRUST

ENROLLMENT FORM – SELF-PAY PARTICIPANT

Check one _____ Single _____ Family _____

____ New Enrollee _____ *HIPPA Special Enrollee _____ Re-enrollee _____ **Late Enrollee

Change ____ Type of Change_____ Date of Change_____

First Name	Middle Initial	Last Name		Social Security #
Address, Apt/Box		City	Phone # ( ) -	
State	Zip	Date of Birth	Circle one: Sex- M or F Circle one: Married Single Other	
1st) Beneficiary's Name			Relationship	
2nd) Contingent Beneficiary			Relationship	
1st) Beneficiary Address:			Telephone ( ) -	
2nd Contingent Address:			Telephone ( ) -	

Single (self-pay) premium $376.00 per month; Family (self-pay) premium $862.00 per month

(1) To the best of my knowledge and belief, the above information is complete and correct. I hereby authorize payment of medical benefits to preferred providers for those charges covered under the plan. I also authorize release to or by The Maritain Company of any medical information including copies of medical records or insurance information for payment purposes. **Initial _____**

(2) I hereby apply for the insurance benefits for which I am now eligible, under the group policy issued to the Ohio Harness Horsemen's Association by The Meritain Company. I reside in the State of Ohio, and certify that at least 75% of my earned income is derived from training and/or driving harness horses, with at least 40% of my programmed starts or a minimum of 30 programmed starts per year at Ohio commercial racetracks and/or county fairs. I will provide IRS tax filings or W-2 forms in the event of challenged eligibility. Out-of-state stake races, early closers and late closers are excluded from the calculation. I further agree to prove such in the event of a challenged eligibility.

Initial _____

(3) I am and will continue to be a member of OHHA in good standing. **Initial _____**

(4) HIPAA Verification – Check here if you have no credible insurance coverage at any time during the last twelve (12) months, or have had a break in service (a period of 63 consecutive days during which you have not had any credible insurance coverage). **Initial _____**

***HIPAA Special Enrollees:** 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, regardless of whether you had other health coverage.

Notice: Those 65 and older are not qualified for OHHHIT Insurance coverage

4/1/2020

Signed_____ Date_____

THIS APPLICATION MUST BE COMPLETED AND SIGNED BEFORE COVERAGE WILL BE CONSIDERED

FOR OFFICE USE ONLY

Elig. Date	Eff. Date	PPO	Division Code

Dependent Information

Full Name of Family Member	Sex	Birth Date	Full Time Student (if 19 or older)	Social Security #
Spouse				
Child			_____ yes _____ no	
Child			_____ yes _____ no	
Child			_____ yes _____ no	
Child			_____ yes _____ no	
Child			_____ yes _____ no	
Child			_____ yes _____ no	

Change _____ Date of Change _____

Description of Change:

_____

_____

_____

Does Spouse have other coverage? _____ Name of Carrier:_____

Policy#_____