ODA WELLNESS TRUST
ODA MEMBER BENEFIT

DEDUCTIBLE/PLAN CHANGE REQUEST
2024 OPEN ENROLLMENT

Please use this form to indicate any changes effective January 1, 2024

Office Name: _____ **Group #** _____

Employee Name(s)	**2024 Plan Name and Deductible** (see chart below)	**2024 Coverage** (EE, EE+SP, EE+Ch, EE+F)	**2024 Monthly Cost** (see renewal)*

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 SBC's available at: https://www.odawt.org/odawt-plans/compare-plans/

Plan Change effective date: 1/1/2024

Employer Signature: _____ **Date:** _____

E-Mail Address: _____

***The 2024 office renewal is not final until all eligible employees have been evaluated.**

Employee/Child(ren) Coverage Tier = no more than 2 children

An email will be generated to confirm receipt of all faxes submitted to ODAWT (614) 340-9444 within one business day. Please include an email address the fax receipt confirmation should be sent If you do not receive a confirmation of fax receipt (please check your junk/spam file), the ODAWT has not received your fax.

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