



ODA MEMBER BENEFIT

**DEDUCTIBLE/PLAN CHANGE REQUEST
2025 OPEN ENROLLMENT**

Please use this form to indicate any changes effective January 1, 2025

Office Name: _____ Group # _____

Employee Name(s)	2025 Plan Name and Deductible (see chart below)	2025 Coverage (EE, EE+SP, EE +Ch, * EE+F)	2025 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: 1/1/2025

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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