ODA Wellness Trust

Administered by: Medical Mutual

Send forms to:
Ohio Dental Association Services Corporation
1370 Dublin Road; Columbus, OH 43215-1098
Phone: 614-486-2700
Fax: 614-340-9444

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.