WELLNESS TRUST
ODA MEMBER BENEFIT

Fax (614) 340-9444
Phone (800) 282-1526
Email: insurance@oda.org
1370 Dublin Road
Columbus, OH 43215-1098
www.odawt.org

Election Change Form - Add Dependent(s)

Employer Name:	
Group #:	
Subscriber Name:	Last First MI
Address:	
City, State ,Zip	

Change Effective Date:	

Indicate Reason for Enrollment or Election Change:

☐	**Due to: Birth (within last 30 days)** Date of Birth: _____ Name: _____ Gender: _____ Social Security Number: _____ ***(If you do not yet have a social security # for a newborn, please provide by phone upon receipt.)***
☐ *	**Due to: Marriage (return with Marriage Certificate)**
☐ *	**Due to Qualifying Event** *(documentation must be included)*
☐ *	**Due to: Open Enrollment (10/15 to 11/15 to be effective 1/1)**

** Submit Election Change Request with updated Personal Health Questionnaire*

Subscriber Signature :	
Date :	

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Personal Health Questionnaire (PHQ)

Employee Information:				Employer Name:
Title	First	MI	Last	
Email address:				Date of Hire:
Daytime Phone #: ( )				Marital Status: (select one) Married ☐ Divorced ☐ Separated ☐ Single ☐
HOME - Street Address:		City:	State:	Zip:
COUNTY OF RESIDENCE:				

Are you planning to enroll in your employer's health benefit plan? ☐ **Yes** ☐ **No**

If you selected NO, check one of the following, skip the remainder of the form and sign the bottom of page 4.
☐ Covered by Spouses plan ☐ Not Eligible ☐ Do Not Want Coverage ☐ Other Reason_____

* **If you selected "YES", please complete the rest of this form and sign the bottom of page 4.**
* Answer the following questions for yourself and for eligible enrolling family members.
* Include additional sheets for detailed explanations or additional dependents.
* All questions must be answered or the form may not be accepted.

I Demographic, Build and Tobacco Use (in last year)

	Primary Applicant	Spouse	Child 1	Child 2	Child 3	Child 4
Title:	☐ Dr ☐ Mr ☐ Ms	☐ Dr ☐ Mr ☐ Ms				
First Name:						
Middle Initial:						
Last Name:						
Social Security #:						
Date of Birth:	/ /	/ /	/ /	/ /	/ /	/ /
Gender:	☐ M ☐ F	☐ M ☐ F	☐ M ☐ F	☐ M ☐ F	☐ M ☐ F	☐ M ☐ F
Height:	Ft In	Ft In	Ft In	Ft In	Ft In	Ft In
Weight:	Lbs	Lbs	Lbs	Lbs	Lbs	Lbs
Tobacco Use:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Home Zip: (if different than primary applicant)						

II Current Coverage

Do you or other listed dependents have current health coverage? ☐ **Yes** ☐ **No** *If yes, please complete the* section below:

Current Policyholder Name: *(if other than ODAWT applicant)*		
Name of Insurance Company:		
Dates Covered: From: _____ Through: _____	Continuing current coverage? ☐ Yes ☐ No	
Current Coverage Through:	☐ Current Employer ☐ Spouse Employer ☐ Parent ☐ Individual ☐ Medicaid	
Plan Name or Group Sponsor:		

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III Other Coverage

Medicare Information:
Are you or any dependent covered by Medicare? ☐ Yes ☐ No If yes, please complete the section below:

Policyholder Name	Medicare Number	Part A Effective Date	Part B Effective Date	Reason for Medicare
				☐Age ☐End Stage Renal ☐Disability, Indicate Reason: _____
				☐Age ☐End Stage Renal ☐Disability, Indicate Reason: _____

Important Notice for Medicare Eligible Individuals: If you are entitled to Medicare, you should enroll in and maintain that coverage. When the Ohio Dental Association Wellness Trust ("ODAWT" or "MEWA") is the secondary payer to Medicare Part B, the MEWA will coordinate benefits as if you were covered under Part B, even if you are not. This can result in you being responsible for costs that would have been paid by Medicare. ODAWT can assist you with any questions.

IV	Medical Conditions & Treatments		
	Has any person listed above seen a medical provider, had a treatment recommended, received care (including prescriptions) or been hospitalized for any of the following:		
	Check "YES" or "NO" for each question. Please complete ADDITIONAL DETAIL TABLE on pg 3 for ALL "YES" answers.	**YES**	**NO**
1	**Autism Spectrum Disorders** (Autism, Asperger's Syndrome and Pervasive Development Disorders) – **If yes, list types and frequencies of Therapies received:** _____ _____ _____		
2	**Cancer --** If yes, list location and type of cancer below Location and type of cancer _____ **Check one**: ☐ Stage 1; ☐ Stage 2; ☐ Stage 3; ☐ higher Date of remission (if applicable) _____		
3	**Cardiac or Heart Disease / Disorder** (i.e. arrhythmia, aneurysm, heart failure, heart valve disorder) **If yes, check all that apply:** ☐ heart attack ☐ bypass surgery or angioplasty on **single** vessel, or ☐ bypass surgery or angioplasty on **multiple** vessels ☐ **ANY other heart conditions (list here)**: _____		
4	**Diabetes --** ☐ Type 1 OR ☐ Type 2 If yes, list 3 most recent HbA1c / fasting blood sugar levels: 1) 2) 3)		
5	**High Cholesterol --** If yes, list 3 most recent readings: 1) 2) 3)		
6	**High Blood Pressure --** If yes, list 3 most recent readings: 1) 2) 3)		
7	**Arthritis** (i.e. rheumatoid, osteo, psoriatic, gout)		
8	**Autoimmune Disease** (i.e. lupus, MS, anemia)		
9	**Back Disorder** (i.e. degenerative disc disease, herniated disc, spinal fusion, spondylitis, strain)		
10	**Benign Growth** (i.e. tumor, cyst) location: _____		
11	**Muscular Disorder**		
12	**Bowel & Digestive Disorders** (i.e. colitis, regional enteritis, calculus of gallbladder)		
13	**Circulatory System Disease** (i.e. stroke, arterial / vascular diseases)		

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V	Medical Conditions & Treatments (continued)	YES	NO
14	**Immunodeficiency** (i.e. AIDS, HIV+, hemophilia)		
15	**Kidney Disorder** (i.e. nephritis, renal failure, dialysis)		
16	**Liver disease** (i.e. cirrhosis, hepatitis, A, B, C, E)		
17	**Mental Illness** (i.e. mild or major depression, anxiety, bipolar disorder, or schizophrenia)		
18	**Counseling** (current or prior)		
19	**Respiratory** (i.e. asthma, allergies, pneumonia, COPD, emphysema, bronchitis)		
20	**Stomach** (i.e. ulcer, acid reflex, GERD)		
21	**Substance dependency** (i.e. alcohol, drug)		
22	**Transplants --** If yes, list organ(s) _____		
23	**Endocrine & Metabolic Disorders** (i.e. dwarfism, cystic fibrosis, lipidosis, amyloidosis)		
24	**Congenital Abnormalities or Newborn Complications** (i.e. cleft lip or pallet, heart anomalies, Down syndrome, spina bifida, muscular dystrophy)		
25	**Intracranial, Spinal Cord or Paralysis Injuries or Disorders**		
26	**Major Trauma, Amputation or Burns**		
27	**Is anyone currently taking prescription medication(s)?**		
28	**Has anyone had any of the following for a serious illness in the past 5 years?**		
	a) Treatment……		
	b) Hospitalization……		
	c) Surgery……		
29	**Is anyone currently:**		
	a) Hospitalized or confined in a treatment facility?		
	b) Confined at home, incapacitated or incapable of self-support?		
30	**Is any of the following pending?**		
	a) Treatment (medical treatment or diagnostic testing)……		
	b) Hospitalization……		
	c) Surgery……		
31	**In the past 5 years, has anyone enrolling had symptoms of any serious medical condition not yet indicated on this form?**		

VI	Pregnancy and Childbirth	YES	NO
32	**Is anyone pregnant? (If yes, please answer a, b, c, d below)**		
	a) The due date is:	/ /	
	b) Is this a High-Risk Pregnancy, any complications or bleeding?		
	c) Previous C-section or pre-term birth?		
	d) Are multiple births expected? If so, please check: ☐ twins ☐ triplets ☐ more		

***If you marked "YES" to any item on Pages 2 and 3, please complete ADDITIONAL DETAIL TABLE on Page 4 or this form will not be accepted.**

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***If you marked "YES" to any item on Pages 2 and 3, please complete ADDITIONAL DETAIL TABLE below or this form will not be accepted.**

ADDITIONAL DETAIL TABLE – Please Fill In Details Below For All Questions Answered "YES"							
Question #	Name of Individual	Condition / Diagnosis	Date of Onset	Last Date Treated	Treatment / Drug	Still taking? Y / N	Degree of Recovery

I acknowledge and agree that in the event that information has been intentionally omitted or misrepresented, the benefits carrier may deny or limit coverage and the Ohio Dental Association Wellness Trust service agreement may terminate for breach. In such cases, I understand that Ohio Dental Association Wellness Trust or the carrier may change my rate. I certify that the statements above are true and correct to the best of my knowledge. I understand that this form is used for information only and does not bind coverage. Ohio Dental Association Wellness Trust gathers this information for statistical and actuarial use only. This information is not to be used in connection with any decisions or actions regarding my employment. Prospective employees in Michigan should not provide information regarding height or weight. In compliance with requirements for GINA, Ohio Dental Association Wellness Trust is not requesting genetic information. Ohio Dental Association Wellness Trust Notice of Privacy Practices provides more detailed information. I have a legal right to review the Notice of Privacy Practices before I sign this consent, and I am encouraged to read it in full. I have a right to request restrictions on how my protected health information is used and disclosed. The Ohio Dental Association Wellness Trust and my health plan are not required by law to grant my request. However, if any request is granted, the Ohio Dental Association Wellness Trust and my health plan are bound by their agreement. I have a right to revoke this consent in writing, except to the extent the Ohio Dental Association Wellness Trust or my health plan have already used or disclosed my protected health information in reliance upon my consent. I will notify Ohio Dental Association Wellness Trust of any health or enrollment related changes that occur after signing this form up to the effective date on the health plan.

Employee SIGN HERE AND DATE:

➢ _____ 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.

Client Privacy Notification

Thank you for completing the requested information above. Any non-public personal health information (i.e. name with address and/or social security number and detailed health information (protected health information) that you provide via hard copy or through the Lewis & Ellis, Inc. Online Data Collection Website will be used solely for the purpose of providing risk assessment to the Multiple Employer Welfare Agreement (MEWA) association group (Association) that will provide a health benefits quote to your employer. Lewis & Ellis is acting as a Business Associate to the MEWA / Association / Trust and is subject to certain provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations. Lewis & Ellis will not sell, license. Transmit or disclose this information outside of Lewis & Ellis except as a) necessary for Lewis & Ellis to provide the services on behalf of the MEWA / Association / Trust, b) expressly authorized by you, c) necessary for backup documentation purposes, or d) required by law.

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