O.H.H.H.I.T

Ohio Harness Horsemen's Health Insurance Trust

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Grove City, Ohio 43123
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SELF-PAY APPLICATION FORM

PLEASE RETURN THE INFORMATION, BELOW

Ohio Resident Information

Last Name, First Name, Middle Initial:			
Address:			Phone Number:
Date of Birth: / /	Social Security Number: - -	Gender (Check One) ☐ M ☐ F ☐ Other ______	
Marital Status: (Check One)	☐ Single ☐ Married ☐ Other__________		USTA Number:

Primary Beneficiary (name/relationship):
Address:________________________________ Telephone: ( ) -
Contingent Beneficiary (name/relationship):
Address:________________________________ Telephone: ( ) -

(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 Meritain 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 full-active member of the OHHA in good standing. **Initial** __________

(4) I certify that I am fully compliant with Workers Compensation and understand that coverage is for medical and prescription only, no occupational injury or illness claims are covered by the Plan as outlined in the Summary Plan Document. **Initial** __________

(5) 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

I have read the Program Guidelines that are included as part of this Application at page 2 of 2. My initials and signature below certify that I am in compliance with and agree to comply with all criteria as an Ohio resident driver or trainer and for any Ohio resident grooms to be considered for and receive coverage under me on the Plan. If any program eligibility or requirements are not fulfilled or met on a continuing basis going forward, I understand my lack of eligibility will result in termination from the Plan._______ Initials

Trainer Printed Name (Date) ____________________________**Trainer Signature:**___________________________

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	

Change _____ Date of Change __________________________

Description of Change:

____

____

____

Does Spouse have other coverage? _________ Name of Carrier:__________________ Policy#__________________

Program Requirements:

To Enroll in the O.H.H.H.I.T. Self-Pay Insurance Plan, the Applicant:

(A) Must be a current Member of the OHHA.

(B) Must reside in the State of Ohio.

(C) If a Licensed Trainer or Driver, must earn at least 75% of his or her income training or driving harness horses, with at least 40% of his or her programed starts or at least 30 programed starts per year at Ohio racetracks and/or county fairs. Out-of-state stake races, early closers and late closers are excluded from the calculation.

(D) If you have had any prior health insurance coverage, The Meritain Company requires a Certificate of Health Coverage.

(E) A copy of your Ohio Motor Vechicle Driver's License must accompany the application.

(F) I will provide IRS tax filings or W-2 forms in the event of challenged eligibility.

A copy of the certificate, a completed enrollment application and a check for the single or family coverage premium should be returned to the office as soon as possible.

Insurance coverage will become effective the first day of the month, if the application is received before the 15th of the month, after the 15th coverage will begin the following month on the 1st. However, the final decision as to eligibility will be made only if all conditions (above) have been met.

Premium rates: Single Coverage - $431 per month
Family Coverage - $997 per month

Please make checks payable to: Ohio Harness Horsemen's Health Insurance Trust or O.H.H.H.I.T.

(Your check will not be deposited until we receive notification from The Meritain Company that your insurance has been approved. If the check is returned by the bank for insufficient funds, that will result in the cancellation of this insurance application).

This insurance coverage will become void at age 65 or Medicare eligible. The Ohio Harness Horsemen's Health Insurance Trust does not provide supplemental insurance for Medicare or offer COBRA coverage.

For applications or more information, contact the OHHA office, 1-800-353-6442 3.2024