OHIO HARNESS HORSEMEN'S HEALTH INSURANCE TRUST

ENROLLMENT FORM

Breeding Farm Employee

Farm Name _____

____ New Enrollee _____ *HIPPA Special Enrollee _____ Re-enrollee _____ **Late Enrollee

Change ____ Type of Change_____ Date of Change_____

First Name	Middle Initial	Last Name	Social Security #

Address, Apt/Box	City	Phone #
		( ) -

State	Zip	Date of Birth	Circle one: Sex- M or F Circle one: Married Single Other

1st) Beneficiary's Name	Relationship
2nd) Contingent Beneficiary	Relationship
1st) Beneficiary Address:	Telephone ( ) -
2nd) Contingent Beneficiary:	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 Maritain 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 will provide IRS tax filings or W-2 forms in the event of challenged eligibility. I reside in the State of Ohio, and certify that at least 75% of my earned income is derived from employment at a qualified Ohio Standardbred breeding Farm.

(3) I am and will continue to be a member of the Ohio Harness Horsemen's Association in good standing. Initial _____

(4) Attach proof of residency

*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.

Signed_____ Date_____

THIS APPLICATION MUST BE COMPLETED AND SIGNED BEFORE COVERAGE WILL BE CONSIDERED

FOR OFFICE USE ONLY

Elig. Date	Eff. Date	PPO	Division Code

4/01/20