Ohio Funeral Directors Association

HEMA Health Enrollment Management Agency

Fax or email completed form to:

Fax: (614) 486-5358 **Email: Laura@OFDAonline.org**

INDIVIDUAL ENROLLMENT FORM

Employer Name:	**Employer Zip Code:**
Employee Name:	County of Residence:
Residence Address:	Zip:
City: State:	Phone 1 : Cell – Home - Work
Email:	Phone 2: Cell – Home - Work

Requested Effective Date: _____

						Preferred Coverage Options			
	Name	**Date of Birth**	**Gender** M/F	**Medicare[1]** Y/N	**Tobacco Use** Y/N	**Medical** Y/N	**Dental** Y/N	**Vision** Y/N	**Life** Y/N
Primary									
Spouse									
Child 1									
Child 2									
Child 3									
Child 4									

[1] Medicare Part A Effective Date: _____ Part B Effective Date: _____
Please include a copy of your Medicare Card

Current Provider:_____ **Renewal date**:_____

Other notes:

HEMA Office Use

Subsidy:	Premium:	App ID:
Net Premium:	Eff Date:	Plan: