Ohio Association of Health Plans Membership Application

Please Print:

Organization/Company/Individual Name _____

Name of Primary Contact _____ Title _____

Address _____

City _____ State _____ Zip _____-_____

Phone _____ FAX _____ E-mail _____

Company Website: _____

Other individuals to receive association mailings:

1. Name _____ Title _____
   Address (if different than above) _____
   Phone _____ FAX _____ E-mail _____

2. Name _____ Title _____
   Address (if different than above) _____
   Phone _____ FAX _____ E-mail _____

3. Name _____ Title _____
   Address (if different than above) _____
   Phone _____ FAX _____ E-mail _____

Membership Categories (please check one):

- ☐ Licensed Health Plan
- ☐ Developing Licensed Health Plan
- ☐ Affiliate
- ☐ Supporting

Annual Dues

Please Contact OAHP for Dues Amount

Nature/Scope of Business:

_____

How did you hear about OAHP: _____

Form completed by _____ Date: _____

Dues payments are deductible by members as an ordinary and necessary business expense. However, contributions or gifts to the Ohio Association of Health Plans are not deductible as charitable contributions for federal income tax purposes.

Please return application with a brief company description and check made payable to:

Ohio Association of Health Plans
230 East Town Street, Suite 200
Columbus, Ohio 43215

Phone (614) 228-4662 FAX (614) 228-5816