Ohio Association of Health Plans Membership Application

Please Print:

Organization / Company Name: _____

Name of Primary Contact: _____

Title: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Company Website: _____

Other individuals to receive association correspondence and information:

1. Name: _____ Title: _____
   Address (if different than above): _____
   Phone: _____ Email: _____

2. Name: _____ Title: _____
   Address (if different than above): _____
   Phone: _____ Email: _____

3. Name: _____ Title: _____
   Address (if different than above): _____
   Phone: _____ Email: _____

Membership Categories (please check one): Annual Dues

☐ Health Plan
☐ Affiliate Member
☐ Supporting Member

} **Please Contact OAHP for Dues Amount***

Nature / Scope of Business:

_____

How did you hear about OAHP? _____

Form completed by: _____ Date: _____

*Health plan members that are Medicaid managed care plans and/or MyCare Ohio plans are subject to an additional annual surcharge. Dues payments are deductible by members as an ordinary and necessary business expense to the extent listed on annual membership invoice. 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
20 East Broad Street, Suite 701
Columbus, Ohio 43215

Phone (614) 228-4662 Email: sbewley@oahp.org