

RE: **OTA Health Plan Information**

Dear Township Officials:

With the continuation of rising health care costs it makes sense to share your risk with the statewide association. By now you are familiar with **OTARMA**, the premier property and liability coverage program for Ohio Townships. The same philosophy that guides OTARMA holds true with the **Ohio Township Association Health Plan, (OTAHP)**. Together, these programs are designed to meet your unique requirements.

The **OTA Health Plan** has grown dramatically over the years. This has been a direct result of superior service and high quality benefit products! Our annual proposals include a complete comparison and analysis of available options. We have included the roster of companies and products now available to your township through the Burnham & Flower Insurance Group.

Thank you for choosing to learn more about the OTA Health Plan. We are anxious to tailor a plan to meet your township's needs and budget. As you know, your initial premium is based on the health conditions of those participating. For us to provide a firm and accurate quote, please have each covered person complete an **OTA Health Questionnaire** found in this packet. Feel free to make copies as needed. Please return completed questionnaires, a copy of your current benefits, and a copy of your most recent billing to our office for a quote and comparison.

Please feel free to contact our office at (800) 748-0554 if you have any questions. We look forward to serving all of your insurance needs.

Sincerely,

Sean M. Sprouse, BRM
Employee Benefit Consultant

The Value and Benefits of Working with The Burnham & Flower Insurance Group

One number to call for all your insurance concerns:

1-800-748-0554

•Medical, Dental, Vision, Life, Disability, AFLAC

OTA Endorsed Agency

•Township Specialists

Annual Reviews and Comparison of all Available Options

•Access to the Top Insurance Carriers in the Nation

Service Staff of over 60 Professionals

•Local Service and Representation available

•In-house Insurance Consultants

Committed to a Long-term Relationship and Success

Tom Armintrout
Employee Benefits Manager
Tel: 1-800-748-0554 ext. 3118
Fax: 1-269-276-4066
E-mail: tarmintrout@bfgroup.com
Web: www.bfgroup.com

Brenda Schuur
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Web: www.bfgroup.com

Great Service Is Our Priority!

Burnham & Flower
INSURANCE GROUP





The **Ohio Township Association
Health Plan (OTAHP)**

Your Leader in Exclusive Benefit Solutions!

Group Health (State-wide)

American Community
American Medical Security
Anthem Blue Cross/Blue Shield
Humana
John Alden
Medical Benefits
Medical Mutual
Midwest Security
United HealthCare

Group Health (Regional)

Ault Care (Canton Area)
COSE (Cleveland Area)
Health Assurance (Eastern Ohio)
Kaiser (Cleveland Area)
Tri Rivers (Dayton Area)
Various Chamber of Commerce Plans

**Group Life, Disability,
Dental & Vision**

American United Life
Compdent
Delta Dental
The Standard
UNUM/Provident
Vision Service Plan (VSP)

TPA Services

Anthem Blue Cross/Blue Shield
Central Benefits
Med Ben
Medical Mutual

Long-Term Care

AFLAC
UNUM/Provident

**Volunteer Fire Dept.
Sickness & Accident**

Provident

Section 125/Cafeteria Plans

AFLAC
Critical Illness
Dental
Disability
Life
Vision

Individual Medicare

Supplements & Major Medical

American Community
Anthem BC/BS
Golden Rule
Medical Mutual

*The OTAHP
614.436.3574 or 800.822.2682
6797 N. High St., Ste. 131
Worthington, OH 43085
eMail: info@bfgroup.com*

Your Township Specialist

Preliminary information needed to accurately produce a quotation and presentation of your Ohio Township Association Endorsed Employee Benefits.

Township _____ No. of Employees _____

County _____ /Contact Name _____ /Position _____

Telephone: Day_() _____ /Business_() _____

Address _____

Does your township have a resolution which allows officials to participate in a group...

Health Insurance Plan? YES _____ NO _____

Life Insurance Plan? YES _____ NO _____

Critical Illness/Cancer? YES _____ NO _____

Accident Plan? YES _____ NO _____

Does the township have a volunteer fire department? YES _____ NO _____
Number of emergency vehicles: _____

Does the township currently have or had group health benefits of any kind? YES _____ NO _____

If yes, overall health of group: Excellent _____ Good _____ Fair _____ Poor _____

Concerns with current plan: _____

Current plan renewal date: _____

Current Agency: _____

Percentage paid by employer: _____ %
Deductibles/Copays: _____

Vision & Dental: _____ Prescription Drug: _____ Weekly Income: _____

Critical Illness Cancer Insurance: _____ Premiums: _____

Total Monthly Premium: _____

Dollar amount currently spent on all employee benefits per month: _____

Date and time of next meeting: _____

Directions from Columbus:



OTA Health Plan Questionnaire (Employee)

Township _____ County _____

Applicant		D.O.B.		Social Security Number		Height	Weight
Dependent to be Covered	Age	Height	Weight	Dependent to be Covered	Age	Height	Weight
1.				4.			
2.				5.			
3.				6.			

Coverage Applying for:

<input type="checkbox"/> You	<input type="checkbox"/> You and Spouse	<input type="checkbox"/> You, spouse and children	<input type="checkbox"/> Medicare Supplement
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A. Check all medical conditions, diseases, listed below for which you or any of your dependents have, or ever have been diagnosed, treated or counseled: (Use Number and Letter to identify conditions in C)

<input type="checkbox"/> Transplant (any organ)	<input type="checkbox"/> Other Lung Disorders	<input type="checkbox"/> Bypass Surgery
<input type="checkbox"/> Connective Tissue Disease	<input type="checkbox"/> Liver Disorder	<input type="checkbox"/> Congestive Heart Failure
<input type="checkbox"/> AIDS/ARC/HIV	<input type="checkbox"/> Congenital Disease/Defect	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Arthritis, Osteo	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Ischemic Heart Disease
<input type="checkbox"/> Arthritis, Rheumatoid	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Other Heart Disorders
<input type="checkbox"/> Back/Spinal Disorder	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Epilepsy	Yes – Give last three blood pressures & dates
<input type="checkbox"/> Spina Bifida	<input type="checkbox"/> Parkinson’s	1. 2. 3.
<input type="checkbox"/> Ulcerative Colitis	<input type="checkbox"/> Alzheimer’s Disease	<input type="checkbox"/> Alcohol or Drug Dependency
<input type="checkbox"/> Diverticulitis Disease	<input type="checkbox"/> Other Neurological Disorders	<input type="checkbox"/> Attempted Suicide
<input type="checkbox"/> Crohn’s Disease	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Anorexia/Bulimia
<input type="checkbox"/> Gastric/Peptic Ulcer	<input type="checkbox"/> Kidney/Urinary Disorders	<input type="checkbox"/> Chronic Depression
<input type="checkbox"/> Other Bowel/Stomach Disorder	<input type="checkbox"/> Tumors/Growths	<input type="checkbox"/> Other Mental/Emotional Disorders
<input type="checkbox"/> Stroke (date)	<input type="checkbox"/> Juvenile Diabetes	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Cancer, Leukemia or Melanoma	<input type="checkbox"/> Yes – Give last three blood sugars & dates	<input type="checkbox"/> Currently Pregnant
<input type="checkbox"/> Emphysema	1. 2. 3.	If so, state expected due date:
<input type="checkbox"/> Chronic Bronchitis	<input type="checkbox"/> Heart Attack/ M.I.	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Coronary Artery Disease	

B. Medical Questions:**Yes****No**

1) Within the past 5 years, have you or your dependents had, or been treated for, or been told that you have any other condition/disorder/disease not listed above? If YES please explain in section C.		
2) In the past 5 years, have you or your dependents been hospitalized, operated on or been advised to have an operation which has not yet been performed? If YES please explain in section C.		
3) Have you or any DEPENDENT listed been treated on an outpatient basis: Testing, rehabilitation, home health care, or Emergency Room within the last 2 years? If YES please explain in section C.		
4) Within the past 5 years, have you or your dependents been on fertility drugs, had a High risk pregnancy, abnormal pap test, or a Venereal Disease? If YES please explain in section C.		
5) Are you or any of your dependents currently taking any prescription medication? If YES please explain in section C.		
6) Do any of the conditions identified above involve Worker's Compensation? If YES, please provide Work Comp Case Number:		
7) Have you or any of your dependents ever been restricted from, or declined for coverage by any carrier? If YES please explain in section C.		

C. Explanation:

Condition/ Question #	Individual's Full Name	Physician's Name and Address	Treatment Duration (from/to)	Diagnosis, Treatment, Prognosis, Medication, Dosage, and Reason (please be specific)

D. Signature:

Complete all sections applicable to your purpose. READ AND UNDERSTAND all of the statements printer on this application. Signify completion, full understanding and acceptance of all terms by signing below.

Your Signature

Date