Funding Provided By:

Administered By:

Benefits Provided Through:

May 30, 2023

Dear Ohio Bleeding Disorders Dental Program Enrollee,

It is time to re-enroll for the Ohio Bleeding Disorders Dental Program. This program is administered by NOHF on behalf of the Ohio bleeding disorders network of treatment centers and chapters.

To maintain coverage on the Dental Program you must meet these guidelines:

- Return the completed Delta Dental Enrollment/Update enclosed
- Stay current with your comprehensive care outlined by your HTC
- Each enrollee with a bleeding disorder must receive at least one cleaning per year
- Provide feedback through the survey provided
- Pay annual enrollment fee by deadline of July 15, 2023

Your coverage will continue from July 1, 2023 through June 30, 2024. If you no longer need or want services throughout the year, please return the enclosed form or email me.

Special thanks to Cascade Hemophiila Consortium for providing the funds to offer Ohio's patients access to a quality, affordable dental insurance plan through Delta Dental. Your coverage includes twice yearly cleanings and also provides 100% payment for covered services, provided by a Delta Dental network dentist after a $100 deductible due to the dentist of your choice up to a maximum of $1,250 per enrollee.

It is vitally important that you take advantage of your twice-yearly cleanings and check-up benefits. Because of increasing premium rates, Northern Ohio Hemophilia Foundation will closely monitor the utilization of those who are on the program *and enrollees who are not using their benefits will be removed from the plan.*

Please be sure to return all forms by July 15, 2023 to NOHF, 17407 Lorain Ave, #206, Cleveland OH 44111 or scan documents to randi@nohf.org.

I am always available for questions or access issues. I can be reached at 330-730-1259 or randi@nohf.org.

Sincerely,

Randi Clites – Program/Advocacy Manager

Ohio Bleeding Disorders Dental Program Re-enrollment

Please send Delta Dental Eligibility Enrollment/Update Form with payment, or request to un-enroll from the program, by July 15, 2023.

Please make sure ALL Enrollees for 2023 are listed on the Enrollment Form (you can make a copy if you need additional space) and be sure it is signed with today's date.

Mail Forms to: Northern Ohio Hemophilia Foundation, 17407 Lorain Ave Ste 206 Cleveland OH 44111 or email them to randi@nohf.org.

Name of Bleeding Disorder Patient/Enrollee:

____

Hemophilia Treatment Center or Hematologist Name:

____

For dental enrollment fee for service from July 1, 2023 – June 30, 2024.

$25 for bleeding disorders patients: _____ X $25 = ________
$50 for dependents or caregivers: _____ X $50 = ________
Total amount due: $________ (Max $200)

The enrollment fee would be a significant financial burden to my family, so I'd like to request financial assistance to pay my 2023 enrollment fee.

Signature required for assistance: ______________________________

Make checks payable to NOHF or Northern Ohio Hemophilia Foundation.

If you would like to make a credit card payment, you can visit the NOHF website at www.nohf.org and make payment under the donation tab for Dental Fee.

Date of online payment: ________

Ohio Bleeding Disorders Dental Program Survey 2023

Family Name: ______________________________

Years on Program: First Year   2-4 years   More than 5 years

If first year, how long were you without Dental Coverage:

____

How many cleanings did you use on the plan in the past year? ____________

Did anyone on your plan meet the maximum $1,250 allowable services? ______

Were you asked to pay more than the $100 deductible to your dentist? ______

Did you have any issues with your dental coverage in the past year? ________

If so, please explain: ____

Any additional comments or concerns: ______________________________

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Eligibility Enrollment/Update

Check: Indiana Michigan North Carolina ✓ Ohio

Client Name: Northern OHIO HEM FND   Client#/Subclient# 00893 0001

Subscriber Information *(please complete for all enrollments/updates:)* Example: ABCDEF123456

Subscriber Name (Last) (First) (M.I.) Sex: Male / Female Status*: ✓ Active / Retiree / COBRA / Surviving

Subscriber Social Security Number Birth Date Coverage Effective Date: 07 01 2023 Hire Date: ——

Street Address Email

Check here if this is a new address

City State ZIP Code

Plan Enrollment/Update Information *(please indicate type of update and fill in appropriate information):*

Type of Update: New Enrollment Reinstatement Change/Correction to Information Termination of Benefits Waive Benefits

Group Transfer
From: Client/Subclient# To: Client/Subclient#

Rate Code Change*
From: To: Effective Date of Change

Change is for: Subscriber / Dependent

Enrollment/Corrections to Information *(please fill in for spouse/dependents for first-time enrollment or corrections):*

SPOUSE Name (Last) (First) (M.I.) Sex: Male / Female

Social Security Number Birth Date Status*: Legal / Surviving

DEPENDENT #1 Name (Last) (First) (M.I.) Sex: Male / Female

Social Security Number Birth Date Status*: IRS Dep. / Disabled / Surviving / Sponsored

DEPENDENT #2 Name (Last) (First) (M.I.) Sex: Male / Female

Social Security Number Birth Date Status*: IRS Dep. / Disabled / Surviving / Sponsored

DEPENDENT #3 Name (Last) (First) (M.I.) Sex: Male / Female

Social Security Number Birth Date Status*: IRS Dep. / Disabled / Surviving / Sponsored

DEPENDENT #4 Name (Last) (First) (M.I.) Sex: Male / Female

Social Security Number Birth Date Status*: IRS Dep. / Disabled / Surviving / Sponsored

*See reverse side for instructions and explanation of codes.

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

I authorize payroll deduction from my earning for any contribution I am required to make.

Subscriber's Signature ____________________ Date ____________

Please read the following information carefully before completing the other side of this form. You should fill out this form if you are enrolling for coverage or changing any information from an earlier enrollment. If you have any questions about filling out this form, your human resources or personnel department can help you.

Subscriber Information – This section must be completed for us to process your enrollment or update your records. All information should apply to you, the primary subscriber. Please print clearly or type.

Effective Date: The date that Delta Dental coverage takes effect for you and/or your dependents.

Status Definitions (Please select only one status):

Active: You are a current/active subscriber.

Retiree: You are retired and your group continues to provide you with dental benefits.

COBRA: You are no longer an active subscriber but you have continued self-paid coverage under COBRA. COBRA requires many employers to offer extended self-paid coverage to certain employees and qualified beneficiaries who lose group medical benefits coverage. **Please check with your human resources or personnel department.**

Surviving: The surviving spouse or child of a deceased subscriber.

Plan Enrollment/Update Information – This section should only be completed if you are: (1) Enrolling yourself or a family member for the first time, or (2) if your benefits were terminated and are not being reinstated or, (3) if you are making changes to your current enrollment information.

Enrollment: Check for first time enrollment for yourself or your dependents.

Reinstatement: Check for reinstatement coverage for yourself or your dependents.

Change/Corrections: Check if any changes are being submitted on the form.

Termination of Benefits: Check only if you are terminating Delta Dental coverage for yourself or a family member.

Group Transfers: When transferring from one group to another, all dependents will transfer unless otherwise indicated. This section should also be completed when transferring to COBRA.

When reporting a change or correction, the information that is incorrect or has changed should be listed on the line titled "from" and the correct information should be listed on the line titled "to".

When changing a rate code, please refer to the following explanation to select the code that describes who is being covered by your Delta Dental program.

Rate Codes:

- Rate 1 Employee Only
- Rate 2 Employee and spouse
- Rate 3 Employee, spouse and children
- Rate 5 Employee, one child, no spouse
- Rate 6 Employee and more than one child, no spouse

Enrollment/Corrections To Information – This section should be completed when: (1) enrolling dependents or, (2) if you have checked Changes/Corrections and are changing information that was previously submitted to Delta Dental. Please include both first and last names of any individuals for whom you are enrolling or submitting a change or correction.

Dependent Status Definitions:

Legal: Your current spouse

Surviving: The surviving spouse or child of a deceased subscriber.

IRS Dependent: An individual who is your dependent child according to the U.S. Internal Revenue Code. This could include your unmarried dependent child who is attending a university, college, community college, junior college or trade school on a full-time basis and for whom you provide principal support.

Disabled: Your permanently disabled child.

Sponsored: A dependent for whom you are legally responsible. Sponsored dependents could include parents, grandparents and foreign exchange students, **but only if specified in your group's contract with Delta Dental.**