



For office use only.
Divider code: _____

Certification of Enrollment Eligibility Oklahoma Society of Certified Public Accountants Group Health Benefits Plan

This document is to certify that you are eligible to enroll in the association plan in accordance with the terms set forth in the Group Benefits Master Agreement. Namely that you are an active member of the Oklahoma Society of Certified Public Accountants or that you are an employee of a member firm working 30 or more hours per week and a full time resident of the State of Oklahoma.

Please sign and date, and return this form to **Beale Professional Services PO Box 60809. OKC. 73146.**

Section 1. Individual OSCPAs Members – please complete if applying for individual coverage.

| Deductible Amount | | |
|---------------------------------------|-------------------------------------|-------------------------------------|
| <input type="checkbox"/> \$1000 | <input type="checkbox"/> \$1500 HSA | <input type="checkbox"/> \$3000 HSA |
| Name: _____ | | |
| Address: _____ | | |
| Phone: _____ Fax: _____ E-mail: _____ | | |
| OSCPA Membership Date: _____ | | |

Section 2. Member OSCPAs Firms – please complete if applying for employer group coverage.

| Deductible Amount (you may select only one.) | | |
|--|-------------------------------------|-------------------------------------|
| <input type="checkbox"/> \$1000 | <input type="checkbox"/> \$1500 HSA | <input type="checkbox"/> \$3000 HSA |
| Name of firm: _____ | | |
| Address: _____ | | |
| Phone: _____ Fax: _____ E-mail: _____ | | |
| Group Contact: _____ | | |
| 1. Number of employees: _____ | | |
| 2. Number of employees with other group health coverage: _____ | | |
| 3. Number of employees who have not met their 30 day waiting period: _____ | | |
| 4. Number of employees enrolling: _____ | | |
| 5. Amount of Employers contribution for each employee: _____ % | | |

Signature: _____ Date: _____