



Central Ohio Self-Insurers' Association

P.O. Box 2914

Columbus, OH 43216-2914

(614) 228-2010

Email: cosiainfo@cosia.org

www.cosia.org

October 27, 2009

Subject: 2010 Membership Renewal

Due: November 16, 2009

Dear Self-Insured Employer and Associates:

Once again it is time to renew your annual membership and take advantage of the many educational and networking opportunities offered by the Central Ohio Self-Insurers' Association.

Your enthusiastic support of our programs during the past year through attendance at monthly meetings, Education Day, and our annual golf outing has enabled COSIA to achieve its mission of assisting members in providing the highest possible standard of self-insured workers' compensation administration.

Enclosed is your membership registration for coming year. Please complete and return the registration, with remittance, by the due date stated above.

****THE COSIA DIRECTORY WILL BE AVAILABLE IN ELECTRONIC FORMAT**
PLEASE MAKE SURE TO SELECT WHICH FORMAT YOU WOULD PREFER ON THE
ENCLOSED ORDER FORM/INVOICE.**

We look forward to another great year of events with COSIA.

Sincerely,

Debbie Murphy
President, COSIA

Enclosure

(Please find Directory Advertising Order Form on reverse side)

Don't give your competitors an edge - advertise in the COSIA Directory!

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DIRECTORY ADVERTISING ORDER

DEADLINE – November 16, 2009

Payment Must Accompany Advertising Order

Company Name _____

Contact Person _____

Email _____

Address _____

Phone _____ FAX _____

The directory is 8 ½” by 5 ½”, printed in black ink on gray paper, with several choices of ad size and price:

I have selected the following ad size for the 2010 COSIA Membership Directory

- Half Page - 3 ½” High x 4 ¾” Wide \$75.00
- Full Page - 7 ½” High x 4 ¾” Wide \$125.00
- Double Page - 7 ½” High x 9” Wide \$225.00
A double page ad (two opposing full pages) at 7 ½” high by 9” wide
(Copy must be submitted sized to fit each page.)
- Business Card - 2” High x 3 ½” Wide \$50.00
Business card ads will be grouped 3 to a page.
- Website Link \$50.00

**YOU MUST SUBMIT
NEW COPY READY ARTWORK
WITH YOUR ORDER.**

**PLEASE EMAIL DIRECTLY TO
KELLY YOKUM AT
keystrokes@columbus.rr.com**

All prices are for copy ready advertisement only.

Any borders used must fall within the ad dimension boundaries except for business card sizes.

Printing quality cannot be guaranteed unless good black and white copy is submitted.

MAKE CHECK PAYABLE AND SEND REMITTANCE TO:

Central Ohio Self-Insurers' Association P.O. Box 2914 Columbus, OH 43216-2914

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Central Ohio Self-Insurers' Association Membership Application for Calendar Year "2010"

Note: The representative listed first is the "designated representative" and will be the only person receiving meeting notices and other mailings. However, if others from your company regularly attend meetings, their names should be listed and dues paid to ensure the financial stability of the Association.

DEADLINE – NOVEMBER 16, 2009

Company Name: _____

Street Address: _____

City: _____

State: _____ Zip: _____

Phone Number: _____ Fax: _____

Self-Insured Risk Number: _____

Please Indicate Membership Status:

_____ Self-Insured Employer (complete section 1)

_____ Self-Insured Employer and Associate Member (complete section 2)

_____ Associate Member (complete section 2)

Section 1

SELF-INSURED EMPLOYER APPLICATION

<u>Representatives: Name</u>	<u>E-mail Address</u>	<u>Fee</u>
1. Designated: _____	_____	\$55.00
2. _____	_____	\$30.00
3. _____	_____	\$30.00
4. _____	_____	\$30.00

If electing to include payment for the monthly meetings in **2010**, along with your membership, please complete the following:
Simply indicate below the number of representatives you wish to pre-register, for each monthly meeting, and include this total with your membership fee.
_____ (number of representatives) x \$25 = \$_____ x 7 monthly meeting = \$_____ Total Dues: \$_____

Self-Insured Employer: business, firm, entity, or corporation qualified as a self-insurer under the Workers' Compensation Act of Ohio.

*****PLEASE INDICATE DIRECTORY FORMAT PREFERENCE: HARD COPY _____ ELECTRONIC _____*****

Make Check Payable to:

Central Ohio Self-Insurers' Association

Mail Remittance and Application to:

**P.O. Box 2914
Columbus, Ohio 43216-2914**

If you have questions contact: COSIA at (614) 228-2010 or Email Cosiainfo@cosia.org



Central Ohio Self-Insurers' Association
Membership Application for Calendar Year "2010"

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DEADLINE – NOVEMBER 16, 2009

Section 2

ASSOCIATE MEMBER APPLICATION

<u>Representatives: Name</u>	<u>E-mail Address</u>	<u>Fee</u>
1. Designated: _____	_____	\$65.00
2. _____	_____	\$40.00
3. _____	_____	\$40.00
4. _____	_____	\$40.00
5. _____	_____	\$40.00
6. _____	_____	\$40.00
7. _____	_____	\$40.00
8. _____	_____	\$40.00

If electing to include payment for the monthly meetings in **2010**, along with your membership, please complete the following:

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_____ (number of representatives) x \$25 = \$_____ x 7 monthly meeting = \$_____ Total Dues: \$_____

Check the Category which best describes your business:

- | | | |
|--|--|--|
| <input type="checkbox"/> Clinic/Physician | <input type="checkbox"/> Managed Care Organization | <input type="checkbox"/> Rehabilitation/Medical Management |
| <input type="checkbox"/> Consulting Firm | <input type="checkbox"/> Medical Service Provider | <input type="checkbox"/> Software Management Products |
| <input type="checkbox"/> Durable Medical Equipment | <input type="checkbox"/> Pharmaceutical Company | <input type="checkbox"/> Third Party Administrator/Insurer |
| <input type="checkbox"/> Law Firm | <input type="checkbox"/> Private Investigator | <input type="checkbox"/> Other: _____ |

Associate Member: individual or business who represents self-insured employers under the Workers' Compensation act or provider of medical, rehabilitation, educational or other services directly or indirectly to self-insured employers.

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