



# Central Ohio Self-Insurers Association Membership Application

**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.**

## 2012 Membership Application

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: _____	_____	\$60.00
2. _____	_____	\$35.00
3. _____	_____	\$35.00
4. _____	_____	\$35.00

If electing to include non-refundable payment for the monthly meetings in **2012**, 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.

**\*\*\*DIRECTORY IS ONLY AVAILABLE IN ELECTRONIC FORMAT FOR THE REMAINDER OF THIS YEAR\*\*\***

**Make Check Payable to:**

**Central Ohio Self-Insurers Association**

**Mail Remittance and Application to:**

**P.O. Box 208  
Westerville, Ohio 43086**



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### Section 2

### ASSOCIATE MEMBER APPLICATION

<u>Representatives: Name</u>	<u>E-mail Address</u>	<u>Fee</u>
1. Designated: _____	_____	\$70.00
2. _____	_____	\$45.00
3. _____	_____	\$45.00
4. _____	_____	\$45.00
5. _____	_____	\$45.00
6. _____	_____	\$45.00
7. _____	_____	\$45.00
8. _____	_____	\$45.00

If electing to include non-refundable payment for the monthly meetings in **2012**, 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: \$\_\_\_\_\_

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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If you have questions contact: COSIA at (614) 560-6070 or Email [Cosiainfo@cosia.org](mailto:Cosiainfo@cosia.org)