UnitedHealthcare®
Oxford

Freedom Plan®
Liberty Plan℠
Freedom Plan® Select℠
Liberty Plan℠ Select

New York Community-Rated Small Group Application – OHP

Oxford Health Plans (NY), Inc. • Oxford Health Insurance Inc. • *www.oxfordhealth.com*

Mailing Address: Group Enrollment Department, 14 Central Park Drive, Hooksett, NH 03106

I. GENERAL INFORMATION

1. **Full Legal Name of Group:**

2. **Primary Address of Group:**
(Street Address
City, State, Zip Code)
No P.O. Box

3. **Plan Administrator/Contact:**

a. Name

b. Title

c. Address
(If different from primary)

City, State, ZIP code

d. Phone Number Ext.

e. Fax Number

f. E-mail Address

g. Add'l Contact Name/ Address

4. **Name and title of person to receive billing statements:**

a. Name

b. Title

c. Address
(If different from primary)

City, State, ZIP code

d. Phone Number Ext.

e. Fax Number

5. **Full legal name of each subsidiary and/or affiliated company whose employees are to be covered (if applicable):**

6. **Nature of Business:**

7. **SIC Code:**

8. **Tax Identification Number:**

II. ADMINISTRATIVE INFORMATION

The term "coverage" means the benefits provided by Oxford, pursuant to the Group Certificate of Coverage.

1. **Effective date:** We request that this coverage be effective: _____.
2. **Anniversary date:** The anniversary date is the first day of the calendar month that is closest to the effective date.
3. **Open enrollment period:** The open enrollment period is the month prior to your anniversary date. The open enrollment effective date is the first of the month following the period.
4. **Total Number of Employees:** _____ / **Number of Temporary/Contracted Workers:** _____
5. **Employee Eligibility:** All full-time, permanent employees who work at least _____ hours per week (minimum 20 hours/week) are eligible.
6. **Number of Current Eligible Employees:** _____
7. **Number of Employees** enrolling with Oxford Health Plans with the new group application: _____
8. **Number of Waivers** for health coverage submitted: _____
9. **Continuation of Coverage:** Are you enrolling any former employees under COBRA or State Continuation Provisions? ❑ Yes ❑ No If yes, how many? _____
10. **Integration with Medicare benefits:** Health benefits covered by Medicare Part A and B are carved out for retired employees aged 65 or over and their dependents aged 65 or over if the group offers retiree coverage.

Eligibility and Termination: The employee will become eligible on the latter of the effective date of this plan or the date selected below (check appropriate date).

CLASS I

Definition of Class I _____

_____

a) **Waiting period** _____ **days/months from date of hire.**

❑ i) **Eligibility**

On the date the employee completes the waiting period.

Termination

Date of termination of employment.

❑ ii) **Eligibility**

First of the month after the employee completes the waiting period.

Termination

On the last day of the calendar month in which employee's employment terminates.

b) **Should the waiting period be waived for rehire?**

❑ Yes ❑ No

(If yes, rehired within _____ month.)

CLASS II

Definition of Class II _____

_____

a) **Waiting period** _____ **days/months from date of hire.**

❑ i) **Eligibility**

On the date the employee completes the waiting period.

Termination

Date of termination of employment.

❑ ii) **Eligibility**

First of the month after the employee completes the waiting period.

Termination

On the last day of the calendar month in which employee's employment terminates.

b) **Should the waiting period be waived for rehire?**

❑ Yes ❑ No

(If yes, rehired within _____ month.)

*If you wish to add a second class, based on plan design, please indicate which class should receive which plan design in the tables on the following page.

III. PRODUCT/PLAN DESIGN

1. Please put a check mark in the appropriate plan box in the tables below for which plan design option you wish to have available to your employees.

80% Coinsurance Plans

Single Deductible		$200	$200	$250	$250	$300	$300	$500	$500	$750	$750
Coinsurance Limit		$5,000	$10,000	$5,000	$10,000	$5,000	$10,000	$5,000	$10,000	$5,000	$10,000
Freedom Plan®	Copayment $5										
	$10										
	$15										
	$20										
Liberty Plan℠	Copayment $5										
	$10										
	$15										
	$20										
Freedom Plan® Select℠ (Non-Gated)	Copayment $5										
	$10										

**Liberty Select is not available with an 80% coinsurance.

Shaded boxes indicate that a particular plan is not available.

70% Coinsurance Plans

Single Deductible		$200	$200	$250	$250	$300	$300	$500	$500	$750	$750	$750	$1,000	$2,000
Coinsurance Limit		$5,000	$10,000	$5,000	$10,000	$5,000	$10,000	$5,000	$10,000	$5,000	$10,000	$25,000	$5,000	$5,000
Freedom Plan®	Copayment $ 5													
	$10													
	$15													
	$20													
	*$25													
Liberty Plan℠	Copayment $5													
	$10													
	$15													
	$20													
	*$25													
Freedom Plan® Select℠ (Non-Gated)	Copayment $5													
	$10													
	$15													
	$20													
Liberty Plan Select℠ (Non-Gated)	Copayment $5													
	$10													
	$15													
	$20													

*Plan includes a $500 Inpatient Hospital Copayment.

Shaded boxes indicate that a particular plan is not available.

2. **Out-of-Network Reimbursement** - 140% of Medicare Rate[1]

3. **Pharmacy Benefit:**

Options	Tier 1	Tier 2	Tier 3	Mail Order	Deductible** (Please select one)
❑ Option 1	$7 copayment	$20 copayment	$40 copayment	2.5x copayment	❑$0 ❑$50 ❑$100 ❑$250 ❑$500
❑ Option 2	$10 copayment	$30 copayment	$60 copayment	2.5x copayment	❑$100 ❑$250 ❑$500
❑ Option 3	$15 copayment	50%	50%	2.5x copayment or 50%	❑$0 ❑$50 ❑$100 ❑$250 ❑$500
❑ Waived Coverage	N/A	N/A	N/A	N/A	N/A

** Deductible applies to Tier 2 and Tier 3 drugs.

Contraceptives ❑ Yes (Standard) ❑ No (Qualified State Exempt Groups Only)

Medicare Part D 28% Subsidy - For the prescription plan design above, do you currently participate or plan to participate with the 28% Government Subsidy for your Medicare eligible retirees? ❑ Yes ❑ No

4. **Other Riders:**

- ❑ Unlimited Skilled Nursing
- ❑ Vision
- ❑ Dental Premium
- ❑ Dental Enhanced
- ❑ Domestic partner
- ❑ Other _____
- ❑ Alternative Medicine
- ❑ $100 Inpatient Hospital Copayment
- ❑ $250 Inpatient Hospital Copayment
- ❑ $500 Inpatient Hospital Copayment
- ❑ Mandated Offering - Dependent Age Extension to 29
- ❑ Coverage for Biologically Based Mental Illness and Children with Serious Emotional Disturbances
- ❑ Coverage for Non Biologically Based Mental Illness Only

SUBJECT TO HOME OFFICE APPROVAL

IV. RATE INFORMATION

Monthly Rates: All new groups are subject to the four-tier rate structure indicated below. Rates must be included in the spaces below for application processing. Please note: All four categories must be completed.

Single	Couple	Parent/Children	Family
$	$	$	$

[1] When a Medicare rate is not available, reimbursement is based upon certain gap methodology, including a gap methodology using relative value data from Ingenix, Inc. We and Ingenix are related companies through common ownership by UnitedHealth Group. When a gap methodology is not available, reimbursement is based upon 50% of the provider's billed charge.

V. BROKER/AGENT INFORMATION

	Broker	Co-Broker	General Agent
1. Name of Payee:			
2. Payee's Oxford Broker Code (Required):			
3. Payee's Social Security # or Federal Tax ID # :			
4. Name of Writing Agent (Required if Payee is a company):			
5. Writing Agent's Oxford Broker Code (Required if Payee is a company):			
6. Commission Split % :			
7. Sales Representative:			
Comments:			

***Important Information Regarding Producer Compensation:**

We pay brokers and agents (referred to collectively as "producers") compensation for their services in connection with the sale of our insured products in compliance with applicable law. We pay "base commissions" based on factors such as product type, amount of premium, group size and number of employees. These commissions are reflected in the premium rate. In addition, we may pay bonuses pursuant to bonus programs established from time to time which are designed to provide incentives to achieve production targets, persistency levels, growth goals or other objectives. Bonuses are not reflected in the premium rate but are paid from our general administrative expenses. It is our policy not to pay commissions to producers with respect to a product for which the customer is also paying the producer a commission or other fee. Please note we also may make payments from time to time to producers for services other than those relating to the sale of policies (for example, compensation for services as a general agent or as a consultant). Producer compensation is subject to disclosure of Schedule A of the ERISA Form 5500 for customers governed by ERISA and subject to form 5500 filing requirements. We have also taken steps to ensure that producers properly disclose their compensation arrangements to their customers, but we cannot guarantee the producer's compliance. For general information on our producer payment arrangements, please go to **www.oxfordhealth.com**. For specific information about the compensation payable with respect to your particular policy, please contact your producer.

VI. CONSENT

AUTHORIZATION FOR BROKER TO ACT AS BENEFITS ADMINISTRATOR

The undersigned hereby requests Oxford to accept the Broker or General Agent named above as an authorized Benefits Administrator for purposes of processing any enrollment transactions for my company's policy (including, but not limited to, Member enrollments, Member terminations, Member address changes, group contact changes, group address changes, plan renewal changes, and group contract terminations).

This authorization shall be effective immediately and shall (check one only):

_____ Remain in place until it is expressly revoked by me in writing.

_____ Remain in place until _____.
DATE

Further, I agree that my company will be bound by the actions performed by the herein-named Broker or General Agent pursuant to this Consent Form. Additionally, I agree that this Consent Form does not authorize anyone to receive individually identifiable health information about any Member. I acknowledge that I must notify Oxford in writing to void this agreement in the event of a change in my company's Broker of Record.

VII. COBRA & EXTENSION OF BENEFITS DATA

1. Do you have any individuals currently on COBRA continuation? ❒ Yes ❒ No
   If yes, identify the number of individuals_____.
2. Are there any dependents of employees who are currently disabled or in the hospital? ❒ Yes ❒ No
   What is the length of the prior carrier's extension of benefits period for disabled employees or dependents? _____

VIII. APPLICANT AGREEMENT

This application and the premium rates proposed by Oxford are subject to Home Office approval in writing by Oxford and may change due to differences in selection of benefits as determined by Oxford. The Applicant hereby acknowledges that this application does not constitute any obligation by Oxford to offer coverage to the Applicant until such application is accepted in writing by the Home Office of Oxford. The Applicant hereby confirms that it will not cancel any health coverage it may currently have in anticipation that this Application will be accepted by Oxford and that Oxford shall have no obligation to provide coverage to Applicant unless this Application is formally accepted in writing by the Oxford Home Office. Further, I hereby certify on behalf of the Applicant that the Applicant has not had group health coverage terminated within the past 12 months due to failure to pay premiums.

Dated at:_____this_____day of_____ 20_____.

_____

Full legal name of firm:_____

The above named company confirms that we employ no more than 50 full-time non-union employees.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 dollars and the stated value of the claim for each such violation.

IMPORTANT: **All signature lines below need to be signed and dated.**

Oxford Health Plans (NY), Inc.

X _____

SIGN HERE Signature of Authorized Officer of the Company Title

X _____

Witness

IMPORTANT: **All signature lines below need to be signed and dated.**

Oxford Health Insurance, Inc.

X _____

SIGN HERE Signature of Authorized Officer of the Company Title

X _____

Witness