Oxford Health Plans®

Application for a New Jersey Small Employer Health Benefits Policy

Oxford Health Insurance, Inc.

Mailing Address: 14 Central Park Drive, Hooksett, NH 03106 ▪ www.oxfordhealth.com

Please print or type

Policy Number (OHI Use Only): ____________________________

❑ **New Policy** ❑ **Change in Policy**

Requested Effective Date: ____________________________

I. POLICYHOLDER INFORMATION

1. **Policyholder (full legal name of company):**

2. **Tax Identification Number:**

3. **Main Address:** Street / City / State / Zip Code

Mailing Address: Street / City / State / Zip Code

Telephone & Facsimile: Fax

4. **Name of Correspondent:**

5. **Type of organization:** ❑ Corporation ❑ Partnership ❑ Proprietorship ❑ Other (explain) ______________

6. **Nature of business (specify):** ____________________________ **SIC Code:** ____________

7. **Number of eligible employees in your company:** ____________________________

REFER TO NEW JERSEY SMALL EMPLOYER CERTIFICATION FOR THE DEFINITION OF AN ELIGIBLE EMPLOYEE.

8. **Number of eligible employees to be insured:** ____________________________

9. **Class or classes to be excluded:** ____________________________

10. **Insurance Requested For:** ❑ Employees Only ❑ Employees and Dependents

11. **Are you subject to the requirements of COBRA?** ❑ Yes ❑ No

12. **Waiting period before employees become insured: (may not exceed 6 months)**

Present employees ____________________ New or rehired employees ____________________

13. **What percentage of the premium will the employer pay?** ____________________

14. Deposit $____________ **Premium Paid:** ❑ Monthly ❑ Quarterly

Premium will be due as of the effective date. The premium for the first month of coverage must be attached.

Affiliates, subsidiaries, or branches (must be included for purposes of participation).

Legal Name and Location	Number eligible employees in this company	Number eligible employees to be insured

II. SPECIFICATIONS FOR COVERAGE

PLEASE SELECT A PLAN FROM SECTION 1 OR 2.

SECTION 1: FREEDOM PLAN & LIBERTY PLAN

HEALTH BENEFITS

Plan: ❑ A ❑ B ❑ C ❑ D ❑ E ❑ HMO

Product: ❑ Indemnity (A or B) ❑ PPO (B or C) ❑ PPO (C or D) - Liberty Network only ❑ POS (C,D, or E)

Network: ❑ Freedom ❑ Liberty

Copayment (Plans C,D,E,HMO): ❑ $5 ❑ $10 ❑ $15 ❑ $20

Deductible (B,C, D,E) ❑ $200 ❑ $250 ❑ $500 ❑ $750 Rider ❑ $1,000 ❑ $2,000 ❑ $2,500

OPTIONS FOR PLANS B, C, D AND E ONLY:

❑ Plan B Coinsurance Option: 80/20% in-network and 60/40% out-of-network

❑ Plan C Coinsurance Option: 90/10% in-network and 70/30% out-of-network

❑ Copayment Physician Visits for Preventive Care at No Charge

❑ Copayment Hospital Confinement at No Charge

Coinsured Charge Limit: ❑ $5,000 Rider ❑ $8,333 Rider

❑ Physical Therapy 90 Rider

❑ Vision Care Rider

❑ Enhanced Dental Rider

❑ Premium Dental Rider

PRESCRIPTION DRUG BENEFITS

Program Type: ❑ Standard (Plan Copay)

Optional Riders (Generic/Preferred Brand/Brand copay) :

❑ $5/$15/$50 ❑ $7/$20/$50 ❑ $7/$15/$35 ❑ $10/$25/$50

Pharmacy Deductible Options (Waived for generic drugs): ❑ None ❑ $50

SECTION 2: FREEDOM PLAN DIRECT & LIBERTY PLAN DIRECT PLANS

HEALTH BENEFITS

Plan: ❑ C

Product/Network: ❑ Freedom Plan Direct ❑ Liberty Plan Direct

Copayment: ❑ $30 ❑ $15 PCP/$25 Specialist

Deductible*: ❑ $500 ❑ $1,000

*These deductible amounts apply for both in- and out-of-network benefits

DIRECT OPTIONS:

Coinsured Charge Limit: ❑ $10,000

❑ Vision Care Rider

❑ Enhanced Dental Rider

❑ Premium Dental Rider

(continued on next page)

II. SPECIFICATIONS FOR COVERAGE (CONT'D)

PRESCRIPTION DRUG BENEFITS

Program Type: ❑ (Standard) $5/$10/$10

Optional Riders (Generic/Preferred Brand/Brand copay) :

❑ $10/$25/$50* ❑ $15/50%/50%*

Pharmacy Deductible Options (Waived for generic drugs): ❑ None* ❑ $50* ❑ $100 ❑ $150 ❑ $250

*Optional Riders: $10/$25/$50 & $15/50%/50% are only offered with the Pharmacy Deductible Options of None and $50.

III. ALL QUESTIONS MUST BE ANSWERED

1. Is there any Group Health Plan:
Now in force and to be continued? ❑ Yes ❑ No
Currently being applied for? ❑ Yes ❑ No
If "Yes" identify the name of the Group Health Plan, give a description of the plan(s) and name of insurance carrier(s)

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2. Name of present or prior group carrier:______________________________
Effective date of prior coverage:______________ Cancellation/termination date:______________
Is the coverage applied for in this application replacing other group insurance? ❑ Yes ❑ No
If "Yes" give reason______________________________
Plan being replaced: ❑ A ❑ B ❑ C ❑ D ❑ E ❑ HMO ❑ HMO-POS ❑ Dual-Contract
❑Other______________________________

3. Has your firm been uninsured for 3 or more months prior to application? ❑ Yes ❑ No

4. What forms of insurance are now or were in force?
❑ Health Benefits ❑ Prescription Drugs (Attach copies of Booklet/Certificate and most recent Billing Statement)

5. Are extended benefits provided in case of termination of health benefits? ❑ Yes ❑ No

6. To the best of your knowledge are there any current or former employees or their eligible dependents whose health insurance is being continued?
❑ Yes ❑ No

Please provide the following information for each current/former employee or dependent on health continuations.

Name of Employee/ Dependent	Date of Birth	Type of Continuation State/ Federal/Extended Benefits	Reason for Termination Disability/Other	Continuation Dates Start End

If additional space is needed, attach a separate sheet, signed and dated.

7. To the best of your knowledge:
A. Are any employees or dependents presently incapacitated? ❑ Yes ❑ No
B. Are any dependent children incapable of self-support due to a physical or mental disability? ❑ Yes ❑ No

III. ALL QUESTIONS MUST BE ANSWERED (continued)

Additional space to explain if Items 1, 2 or 3 were answered "Yes". Refer to the question number, and give details including names, where appropriate.

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IV. AGENT/PRODUCER INFORMATION

Broker:______________________________ ______________________________________
Name Code Address

Broker:______________________________ ______________________________________
Name Code Address

V. SIGNATURE

It is understood that, except as provided under applicable regulations, no individual shall become insured while not actively at work on a full-time basis or retired, and only full-time employees and retirees are eligible. A full-time employee is one who regularly works at least 25 hours per week at his employer's place of business. It is further understood that no agent has power on behalf of Oxford Health Insurance, Inc. to make or modify any request or application for insurance or to bind Oxford Health Insurance, Inc. by making any promise or representation or by giving or receiving any information. It is further understood that no insurance will be effective unless and until the application is accepted in writing by Oxford Health Insurance, Inc. Final rates will be based on enrollment data as of the Policy effective date. No contract of insurance is to be implied in any way on the basis of the completion and/or submission of this application.

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Dated at:____on____________

______________________________ ______________________________
Print Name of Officer, Partner or Proprietor Signature of Officer, Partner or Proprietor

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Witness to Signature

Note: *If there are any modifications to the statements and answers given in this application (i.e., crossed out, whited-out, erased information), the applicant must attest to the modifications by giving a complete signature in the margin near the modification.*

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