



## NY Small Group Application (OHI)

Oxford Health Insurance Inc. • www.oxfordhealth.com

Mailing Address: 14 Central Park Drive, Hooksett, NH 03106 Attn: Group Enrollment Dept.

Freedom Plan® Metro<sup>SM</sup>

Freedom Plan® Direct<sup>SM</sup>

Liberty Plan® Metro<sup>SM</sup>

Liberty Plan® Direct<sup>SM</sup>

Oxford Exclusive Plan Metro/Freedom Network

Oxford Exclusive Plan Metro/Liberty Network

### I. GENERAL INFORMATION

1. Full legal name of group: [Grid]

2. Primary Address of group: [Grid]  
(Street Address  
City, State, Zip Code)  
\*No P.O. Box

3. Plan Administrator/Contact:  
a. Name [Grid]  
b. Title [Grid]  
c. Address [Grid]  
(If different from primary)  
City, State, Zip [Grid]  
d. Phone Number [Grid] Ext. [Grid]  
e. Fax Number [Grid]  
f. E-mail Address [Grid]

4. Name and title of person to receive billing statements:  
a. Name [Grid]  
b. Title [Grid]  
c. Address [Grid]  
(If different from primary)  
City, State, Zip [Grid]  
d. Phone Number [Grid] Ext. [Grid]  
e. Fax Number [Grid]

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

6. Nature of business: [Grid]

7. SIC Code: [Grid]

8. Tax identification number: [Grid]

## II. ADMINISTRATIVE INFORMATION

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

1. **Effective date:** We request that this coverage be effective: \_\_\_\_\_.  
(Month / Day 1<sup>st</sup> or 15<sup>th</sup> / Year)
2. **Anniversary date:** The anniversary date is the first day of the calendar month which is closest to the effective date.
3. **Open enrollment period:** The open enrollment period will be the month prior to your anniversary date. The open enrollment effective date will be 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 Eligible Employees:** Active 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? \_\_\_\_\_

**Eligibility & 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 \_\_\_\_\_ months).

### 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 \_\_\_\_\_ months).

# III. PRODUCT & PLAN DESIGNS

## A. OXFORD EXCLUSIVE PLAN METRO

Referrals are required for both of these plan designs

**Instructions:** Please select a plan option and check off any variable items as provided below.

Plan Options	Freedom Network				Liberty Network	
	<input type="checkbox"/> Plan 1	<input type="checkbox"/> Plan 2	<input type="checkbox"/> Plan 3	<input type="checkbox"/> Plan 4	<input type="checkbox"/> Plan 5	<input type="checkbox"/> Plan 6
<b>Copayment:</b> a. PCP b. Specialist	\$15 per visit \$25 per visit	\$25 per visit \$40 per visit	\$15 per visit \$25 per visit	\$25 per visit \$40 per visit	\$15 per visit \$25 per visit	\$25 per visit \$40 per visit
<b>Out-of-network deductible</b>	\$1,000 Single \$3,000 Family	\$1,000 Single \$3,000 Family	\$2,000 Single \$6,000 Family	\$2,000 Single \$6,000 Family	\$2,000 Single \$6,000 Family	\$2,000 Single \$6,000 Family
<b>Out-of Network Reimbursement</b>	<input type="checkbox"/> 150% of Medicare Rate <input type="checkbox"/> 70% UCR	<input type="checkbox"/> 150% of Medicare Rate <input type="checkbox"/> 70% UCR	<input type="checkbox"/> 150% of Medicare Rate <input type="checkbox"/> 70% UCR	<input type="checkbox"/> 150% of Medicare Rate <input type="checkbox"/> 70% UCR	<input type="checkbox"/> 150% Medicare Rate <input type="checkbox"/> 70% UCR	<input type="checkbox"/> 150% Medicare Rate <input type="checkbox"/> 70% UCR
<b>Inpatient/Outpatient Facility Copay</b>	\$100 per incident (Inpatient/Outpatient)	\$250 per day up to 5 days Inpatient/ \$250 Outpatient	\$500 Inpatient \$150 Outpatient	\$350 per day up to 5 days Inpatient/ \$250 Outpatient	\$100 per incident (Inpatient/Outpatient)	\$250 per day up to 5 days Inpatient/ \$250 Outpatient

**All plans contain:** 70% Out-of-Network Coinsurance    \$10,000 Out-of-Network Coinsurance limit    \$75 Emergency Room Copay

**Additional Benefit Options:**     Vision     Dental Enhanced     Dental Premium     Other: \_\_\_\_\_  
SUBJECT TO HOME OFFICE APPROVAL

Dependent Student Eligibility Cutoff:     Reaching the age of: 23 (standard)     25 (non-standard, additional cost)

**Please select optional prescription drug coverage:** **(Deductible is waived for Generics)**

Options	Generic	Preferred Brand	Non-Preferred Brand	Mail Order	Deductible (Please select one)
<input type="checkbox"/> Option 1	\$10 copay	\$25 copay	\$50 copay	2x copay	<input type="checkbox"/> \$50 <input type="checkbox"/> \$100 <input type="checkbox"/> \$250 <input type="checkbox"/> \$500
<input type="checkbox"/> Option 2	\$15 copay	50%	50%	N/A	<input type="checkbox"/> \$50 <input type="checkbox"/> \$100 <input type="checkbox"/> \$250 <input type="checkbox"/> \$500
<input type="checkbox"/> Waived Coverage	N/A	N/A	N/A	N/A	N/A

Contraceptives:

- Yes (Standard)
- No (Qualified State Exempt Groups Only)

# III. PRODUCT & PLAN DESIGNS

## B. OXFORD EXCLUSIVE PLAN METRO

**Instructions:** Please select a plan option and check off any variable items as provided below.

**Please Select Network:**       **Freedom**     **Liberty**

Plan Options	<input type="checkbox"/> Plan A	<input type="checkbox"/> Plan B
<b>Copayment:</b>		
<b>a. PCP</b>	\$15 per visit	\$25 per visit
<b>b. Specialist</b>	\$30 per visit	\$50 per visit
<b>Outpatient Facility Copay</b>	\$150 per incident	\$300 per incident
<b>Inpatient Facility Copay</b>	\$150 per incident	\$300 per day to 5 day maximum
<b>Emergency Room</b>	\$75	\$75

**Additional Benefit Options:**       Vision       Dental Enhanced     Dental Premium     Other: \_\_\_\_\_  
SUBJECT TO HOME OFFICE APPROVAL

Dependent Student Eligibility Cutoff:     Reaching the age of 23 (standard)     25 (non-standard, additional cost)

**Please select optional prescription drug coverage:**      **(Deductible is waived for Generics)**

Options	Generic	Preferred Brand	Non-Preferred Brand	Mail Order	Deductible (Please select one)
<input type="checkbox"/> Option 1	\$10 copay	\$25 copay	\$50 copay	2x copay	<input type="checkbox"/> \$50 <input type="checkbox"/> \$100
<input type="checkbox"/> Option 2	\$15 copay	50%	50%	2x copay	<input type="checkbox"/> \$50 <input type="checkbox"/> \$100
<input type="checkbox"/> Waived Coverage	N/A	N/A	N/A	N/A	N/A

Contraceptives:

- Yes (Standard)
- No (Qualified State Exempt Groups Only)

### III. PRODUCT & PLAN DESIGNS (CONTINUED)

#### C. FREEDOM PLAN DIRECT AND LIBERTY PLAN DIRECT PLAN DESIGNS

No referrals are required for these plan designs

##### In-Network/Out-of-Network

Options	<input type="checkbox"/> Plan 1	<input type="checkbox"/> Plan 2	<input type="checkbox"/> Plan 3
Copayment	\$15 PCP \$25 Specialist	\$25 PCP \$40 Specialist	\$25 PCP \$40 Specialist
Single Deductible	\$500/\$1,000	\$500/\$1,000	\$1,000/\$2,000
Family Deductible	\$1,000/\$2,000	\$1,000/\$2,000	\$2,000/\$4,000
Coinsurance	90%/70%	80%/60%	80%/60%
Single Max. Out-of-Pocket	\$1,500/\$4,000	\$2,500/\$5,000	\$3,000/\$6,000
Family Max. Out-of-Pocket	\$3,000/\$8,000	\$5,000/\$10,000	\$6,000/\$12,000

Deductibles and out-of-pocket accumulation periods are on a calendar year basis.

Please Select Network:  Freedom  Liberty

Additional Benefit Options:  Vision  Dental Enhanced  Dental Premium  Other: \_\_\_\_\_  
SUBJECT TO HOME OFFICE APPROVAL

Dependent Student Eligibility Cutoff:  Reaching the age of: 23 (standard)  25 (non-standard, additional cost)

Please select optional prescription drug coverage:

(Deductible is waived for Generics)

Options	Generic	Preferred Brand	Non-Preferred Brand	Mail Order	Deductible
<input type="checkbox"/> Option 1	\$10 copay	\$25 copay	\$50 copay	2x copay	<input type="checkbox"/> \$50 <input type="checkbox"/> \$100 <input type="checkbox"/> \$150 <input type="checkbox"/> \$250
<input type="checkbox"/> Option 2	\$15 copay	50%	50%	N/A	<input type="checkbox"/> \$50 <input type="checkbox"/> \$100 <input type="checkbox"/> \$150 <input type="checkbox"/> \$250
<input type="checkbox"/> Waived Coverage	N/A	N/A	N/A	N/A	N/A

Contraceptives:

- Yes (Standard)  
 No (Qualified State Exempt Groups Only)

### IV. RATE INFORMATION

**Monthly Rates:** All new groups are subject to the 4 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
\$	\$	\$	\$

## V. BROKER / AGENT INFORMATION

	Broker	Co-Broker	General Agent
<b>1. Name of Broker/Agent :</b>			
<b>2. Oxford Broker Code (Required):</b>			
<b>3. Social Security # or Fed. Tax ID #:</b>			
<b>4. Broker Street Address:</b>			
<b>5. City, State, Zip:</b>			
<b>6. Telephone Number:</b>			
<b>7. Fax Number:</b>			
<b>8. Email Address:</b>			
<b>9. Commission Split %:</b>			
<b>10. Oxford Sales Representative:</b>			
<b>Comments:</b>			

## VI. CONSENT

### AUTHORIZATION FOR BROKER TO ACT AS BENEFITS ADMINISTRATOR

The undersigned hereby requests Oxford Health Plans 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 Oxford Health Plan 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 Oxford 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. 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 actual versus proposed enrollment, selection of benefits, changes in census data or underwriting criteria, or any other changes in underwriting 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 current 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 the 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 a group health policy 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 and no fewer than 2 full-time non-union employees. I understand that 1099-compensated individuals are not eligible for group coverage with Oxford Health Insurance. 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 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 violation.

Oxford Health Insurance, Inc.

**X**

\_\_\_\_\_  
Signature of Authorized Officer of the Company

\_\_\_\_\_  
Title

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Duly Licensed Resident Agent/Broker



