



### 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

d. Phone Number  Ext.

e. Fax Number

f. E-mail Address

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

a. Name

b. Title

c. Address  
(If different from primary)  
City, State, Zip

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.

1. **Effective date:** We request that this coverage be effective: \_\_\_\_\_.
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).

\*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

Please put a check mark in the appropriate plan box in the tables below for which plan design option you wish to have available for 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
<b>Freedom Plan</b>	Copay \$ 5										
	\$10										
	\$15										
<b>Liberty Plan</b>	Copay \$20										
	\$5										
	\$10										
<b>Freedom Plan Select (Non-Gated)</b>	Copay \$20										
	\$5										

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

 Shaded boxes indicate that 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
<b>Freedom Plan</b>	Copay \$ 5													
	\$10													
	\$15													
	\$20													
<b>Liberty Plan</b>	Copay \$ 5													
	\$10													
	\$15													
	\$20													
<b>Freedom Plan Select (Non-Gated)</b>	Copay \$ 5													
	\$10													
	\$15													
	\$20													
<b>Liberty Plan Select (Non-Gated)</b>	Copay \$ 5													
	\$10													
	\$15													
	\$20													

 Shaded boxes indicate that particular plan is not available.

5. **Usual & Customary Reimbursement Level:**     Standard (70%)                       High (80%)                       Very High (90%)

6. **Pharmacy Benefit:**

Generic/Preferred/Brand     \$7/\$20/\$40\*     \$10/\$25/\$50\*     \$15/50%\*\*     None  
 Pharmacy deductible options\*\*\*:     \$0                       \$50                       \$100                       \$250                       \$500

\*Contains mail-order benefit.    \*\*Does not include mail-order.    \*\*\*Deductible waived for generic drugs.

All pharmacy options include contraceptive coverage

7. **Other Riders:**

- Unlimited Skilled Nursing
- Vision
- Dental Premium
- Dental Enhanced
- Age 25 Dependent Student Cutoff  
(Age 23 is Standard)
- Alternative Medicine
- \$100 Inpatient Hospital Copay
- \$250 Inpatient Hospital Copay
- \$500 Inpatient Hospital Copay
- Mental Health \_\_\_\_\_
- Other \_\_\_\_\_

**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>			

## V I . C O N S E N T

### 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 \_\_\_\_\_.

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.

## V I I . A P P L I C A N T A G R E E M E N T

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 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 Plans. 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.

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

Oxford Health Plans(NY), Inc.

X

Signature of Authorized Officer of the Company

Title

X

Witness

Oxford Health Insurance, Inc.

X

Signature of Authorized Officer of the Company

Title

X

Witness

