Oxford Health Plans

New York Community Rated Group Application

Oxford Health Plans (NY), Inc. • Oxford Health Insurance Inc.

Mailing Address: 14 Central Park Drive, Hooksett, NH 03106

I. GENERAL INFORMATION

❑ **Existing Group** ❑ **New Group**

1. **Full legal name of firm:**

2. **Address of firm;** (Street Address City, State, Zip Code) ***No P.O. Box**

3. **Plan Administrator/Contact:**

   a. Name and Title

   b. Address: (If it differs from address of firm; cannot be a P.O. Box)

   c. Phone Number

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

   a. Name

   b. Title

   c. Address: (If it differs from address of firm; cannot be a P.O. Box)

   d. Phone Number:

   e. Fax Number:

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

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(s).

1. **Effective date:** We request that this coverage be effective: ______________________________.
(Month/Day/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:** ______________________________. OPEN ENROLLMENT PERIOD WILL BE THE MONTH PRIOR TO YOUR RENEWAL DATE, UNLESS OTHERWISE SPECIFIED.
(Month)

4a. Other group health or HMO coverage: Indicate below other group health or HMO coverage, including Oxford Health Plans, which is still in force or which terminated within the past three years.

Type of coverage	Name of carrier	Effective date	If terminated, date terminated

4b. Credit Prior Carrier Deductibles? ❑ Yes ❑ No

Prior Carrier Deductible information: Single: $__________ Family: $__________

5. **Employee Eligibility:** All permanent, full-time employees who work at least ______ hours per week (minimum 20 hours/week).

Are any classes excluded? ❑ Yes ❑ No If yes, indicate classes excluded: ______________________________

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 rehired within ______ months).

c) Are current employees subject to the waiting period?

❑ No ❑ Same as new hires (Standard)

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 rehired within ______ months).

c) Are current employees subject to the waiting period?

❑ No ❑ Same as new hires (Standard)

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

6. **Number of Employees Eligible on Effective Date:** Active Employees _____ Retired Employees _____ (subject to home office approval)

How many employees will enroll with Oxford Health Plans? _____

7. **Continuation of Coverage:** Are there any former employees who have been paying you for coverage since they stopped working for you?

(Either COBRA or State Continuation Provisions) ❑ Yes ❑ No

If yes, please specify who those individuals are:

Name Qualifying Event and Date

____

____

____

III. PRODUCT/PLAN DESIGN

1. **Product:** ❑ Freedom Plan ❑ Freedom Plan Select ❑ Liberty Plan* ❑ Liberty Plan Select

2.

COPAY / DEDUCTIBLE	$200	$250	$300	$500	$750	$1,000
$5						
$10	■					
$15	■	■				
$20	■	■				

*Liberty Plan is not available with a $5, $10, or $15 copay with a $200 or $250 deductible plan. It is also not available on a $15 copay with a $10,000 coinsurance limit.

3. **Coinsurance %:** ❑ 70% ❑ 80%

4. **Coinsurance Limit:** ❑ $5,000 ❑ $10,000

5. **UCR Level:** ❑ Standard ❑ High ❑ Very High

6. **Pharmacy Benefit:**

   a. Generic/Brand co-pay ❑ Yes ❑ No ❑ $2/$5 ❑ $5/$10 ❑ $5/$15* ❑ $7/$20

   b. Deductible ❑ $0 ❑ $50 ❑ $75 ❑ $100

   c. Contraceptives ❑ Yes ❑ No

**Deductible option is not available with this copay combination*

7. **Other Riders:** ❑ Dental Premium ❑ Dental Enhanced

   ❑ $100 Hospital Deductible ❑ $250 Hospital Deductible ❑ $500 Hospital Deductible

   ❑ Vision ❑ Skilled Nursing

   ❑ Mental Health ______________ ❑ Alternative Medicine ______________

   ❑ Other ______________

   Dependent Student Cutoff: ❑ Standard Age 23 ❑ Adjusted Age 25

IV. RATE INFORMATION

Medical

Group location and number of Members in each location:

❑ Bronx _____ ❑ Rockland _____ ❑ Suffolk _____ ❑ Staten Island _____

❑ Brooklyn _____ ❑ Putnam _____ ❑ Queens _____ ❑ Orange _____

❑ Westchester _____ ❑ Nassau _____ ❑ Manhattan _____

Monthly Rates:

	Single	EE/Spouse	EE/Child	EE/Children	Family
$					

V. BROKER/AGENT INFORMATION

	BROKER	AGENT
1. **Full legal name of firm:**		
2. **Address of firm:**		
3. **Contact:**		
4. **Telephone/Fax Number:**		
5. **Social Security # or Fed. Tax ID #:**		
6. **Broker ID Code:**		

VI. 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________________19________.

(Full Legal Company Name)

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.

Oxford Health Plans(NY), Inc.

X

Signature of Authorized Officer of the Company — Title

Witness — Duly Licensed Resident Agent/Broker

Oxford Health Insurance, Inc.

X

Signature of Authorized Officer of the Company — Title

Witness — Duly Licensed Resident Agent/Broker