OXFORD HEALTH PLANS®
A UnitedHealthcare Company

New York Group Application

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

HMO/Liberty Network℠

HMO Select/Liberty Network℠

Freedom Plan®, Freedom Plan® Select℠

Liberty Plan℠, Liberty Plan Select℠

Mailing Address: P.O. Box 7081, Bridgeport, CT 06601-7081
Corporate Address: 48 Monroe Turnpike., Trumbull, CT 06611 ▪ 1-800-444-6222 ▪ www.oxfordhealth.com

I. GENERAL INFORMATION

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

2. **Address of firm:**
   (Street Address
   City, State, Zip Code)

3. **Plan Administrator/Contact:**
   a. Name
   b. Title
   c. Address:
   (If it differs from address of firm; cannot be a P.O. Box)
   d. Phone Number
   Area Code

4. **Plan year-end date:**
   (for purpose of maintaining plan's fiscal records)

5. **Name and title of person to receive correspondence/billing statements:**
   a. Name
   b. Title
   c. Address:
   (Street Address
   City, State, Zip Code)
   d. Phone Number:

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

7. **Nature of Business:**

8. **SIC Code:**

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 as of the first day of ______________________________. (Month/Year)

2. **Anniversary date:** The anniversary date is the first day of the calendar month which is shown in the effective date.

3. **Other group health or HMO coverage:** Indicate below other group health coverage 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

4. **Contribution basis:**

Benefit	Employer contribution percentage
Employee: Health	______________%
Family: Health	______________%

5. **Eligibility and Termination:** Each employee must be actively at work on the date the insurance provided under the Certificate becomes effective with respect to him/her. If the employee is not actively at work on the date the Certificate becomes effective, the employee must wait until the next day on which he/she is actively at work to begin coverage.

   a) **Employee Eligibility:**

   Active Employees: All active, permanent,full-time employees who work at least _____ hours per week (minimum of 30 hours/week).

   Are any classes excluded? ❑ Yes ❑ No

   If yes, indicate classes excluded: ______________________________

   Retired Employees: ❑ Covered ❑ Not Covered

   The definition of a Retired Employee is:

   ❑ an employee who is retired on pension by the employer.

   ❑ an employee who is retired on pension by the employer and who immediately prior to the date of retirement had completed at least ____ years of service with the employer.

   ❑ an employee who is retired from service by the employer and who immediately prior to the date of retirement had completed at least ____ years of service with the employer.

   b) **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 ______________________________

____

i) **Eligibility**

❑ Date on which the employee completes:

*________ months of continuous service, or

*________ days of continuous service.

Termination

❑ Date of termination of employment.

CLASS II

Definition of Class II ______________________________

____

i) **Eligibility**

❑ Date on which the employee completes:

*________ months of continuous service, or

*________ days of continuous service.

Termination

❑ Date of termination of employment.

CLASS I *continued*

ii) Eligibility

❑ On the first day of the calendar month coinciding with or next following the date on which the employee completes:

*________ months of continuous service, or

*________ days of continuous service.

Termination

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

CLASS II *continued*

ii) Eligibility

❑ On the first day of the calendar month coinciding with or next following the date on which the employee completes:

*________ months of continuous service, or

*________ days of continuous service.

Termination

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

* Indicate number of months or days, whichever is applicable, in the space provided above. In (i) above, if there is no waiting period, insert "0" in the space provided for the number of days or months of continuous service. In (ii) above, indicate whether eligibility is first day of the calendar month coinciding with or next following the date on which the employee completes the group specified length of continuous service.

6. **Number of Employees Eligible of Effective Date:** Active Employees _____ Retired Employees _____
7. **Coordination of Benefits:** To the extent permitted by law, all health expense benefits will be coordinated with benefits under any No-Fault Auto Plan, under any other Group Plan and under any Group-Type Plan.
8. **Integration with Medicare Benefits:** Health Benefits covered by Medicare Part A and Part B are carved-out for Retired Employees age 65 or over and their dependents age 65 or over if the group offers retiree coverage.
9. **Dependent Eligibility:** Dependents are defined as follows: •a legal spouse; and •any child who has not reached age 19; and who is not married; and who is chiefly dependent upon the employee for support.

   The term "child" means the employee's children, including any legal stepchild, adopted child, or child for whom the employee or employee's spouse is the court appointed legal guardian.

   If a child is a registered full-time student at a university, college, or similar institution of higher learning, then that child will be covered until the earlier of:

   – the date on which he/she is no longer a registered full-time student:

   – the date he/she reaches age: ❐ 23 ❐ 24 ❐ 25 ❐ 26 **(check one)**

   If a child cannot support him/herself due to mental retardation or physical handicap, the age limitation requirement for such a child is waived provided that the disability or handicap arose prior to attaining the limiting age and the child is chiefly dependent upon the subscriber for economic support and maintenance, provided proof of such incapacity and dependency is furnished to Oxford within thirty-one (31) days.of the child's attaining the limiting age. however, the child must have been covered under this plan or the prior plan on the day before his/her attaining the limiting age.
10. **Plan Exclusions and Limitations:** Common exclusions and plan provisions are attached to this Application. Please refer to your Group Certificate for a complete list of exclusions and limitations.

III. PRODUCT/PLAN DESIGN

1. **Please check the box corresponding to the product selected:**

❑ Freedom Plan ❑ Freedom Plan Select ❑ Liberty Plan ❑ Liberty Plan Select

❑ HMO/Liberty network ❑ HMO Select/Liberty network

2. **Please complete section below:**

Office copayment: ____________
Deductible ____________
Family Multiple ____________
Coinsurance (%) ____________
Maximum out-of-pocket: ____________
UCR ____________

Note: If more than one product/plan design has been selected, please attach a photocopy of this selection to your application.

3. **Please check additional riders selected:**

Prescription Plan:
Copayment Generic Drugs — Generic____ Preferred Brand____ Brand _____
Prescription Deductible (if applicable) _____ Prescription Limit (if applicable) _____
Contraceptives ❐ Yes ❐ No (Qualified State Exempt groups)
Vision Reimbursement _____
Dental Plan Premium _____ Dental Plan Enhanced _____
Outpatient Mental Health _____ Inpatient Mental Health _____
Enhanced Chiropractor Services ($1000) _____
Alternative Medicine _____
DME Unlimited _____
Skilled Nursing Facility 180 days _____
Emergency Room Copayment _____
Inpatient/Outpatient Hospital Copayment _____
Infertility _____ Waive Advanced Infertility _____
Domestic Partner _____
Physical Therapy _____
Other ____

4. Dental Freedom Plan:

Within each class one box must be chosen for in-network and out-of-network coverage.

	In-Network				Out-of-Network			
Class I Preventive	❑ 100%				❑ 80%	❑ 70%	❑ 60%	❑ 50%
Class II Basic Restorative	❑ 100%	❑ 90%	❑ 80%		❑ 80%	❑ 70%	❑ 60%	❑ 50%
Class III Major Restorative	❑ 80%	❑ 70%	❑ 60%	❑ 50%	❑ 50%	❑ 40%	❑ 30%	

Note: *Minimum of 20% difference between in- and out-of-network coinsurance options is required.*

Please check the appropriate deductible and annual benefit maximum amount.

Annual Deductible Per Person
(No In-Network Deductible)
❑ $50
❑ $50
❑ $50
Applies to Class I, II, III services.

Annual Benefit Maximum Per Person
(In-/Out-of-Network)
❑ $1000 / $500
❑ $1500 / $750
❑ $2000 / $1000
❑ $3000 / $1500

Will this plan contain an Orthodontic benefit? (Note: This rider is available only with 75 or more eligible employees by class.)

❑ Yes * ❑ No

* *If yes, please indicate the applicable coinsurance option and lifetime maximum:*

Coinsurance Levels
(In-/Out-of-Network)
❑ 60% / 40%
❑ 50% / 30%
❑ 50% / 0%

Lifetime Maximum Per Person
(In-/Out-of-Network)
❑ $1500 / $750
❑ $1000 / $500

Please check who will be eligible for the Orthodontic benefit: ❑ Children Only ❑ Adults and Children

IV. LARGE CLAIM/MEDICAL HISTORY DATA

1. Are there any employees (i) who for health reasons of any kind have been prevented from performing their normal duties for two consecutive weeks or longer during the past 12 months, (ii) who are, or have been during the past 12 months, on a paid or unpaid leave of absence from the Company, or (iii) who are not expected to be actively at work on the proposed effective date (exclude variations)?

❒ **Yes** ❒ **No** ***If Yes, please give details in the spaces provided on the following page.***

2. Are there any employees, dependents or COBRA continuees covered under your current plan who had claims in excess of $5,000 in the past 12 months?

❒ **Yes** ❒ **No** ***If Yes, please give details in the spaces provided on the following page***

3. To the best of your knowledge, based on claims incurred by the Company's employees or dependents or otherwise are you aware of any employees or dependents with preexisting conditions or who will have medical or surgical treatment in excess of $5,000 in the next 12 months (include pregnancies)?

❒ **Yes** ❒ **No** ***If Yes, please give details in the spaces provided on the following page.***

4. Do you have any individuals currently on COBRA continuation? ❒ **Yes** ❒ **No**

If Yes, identify the number of individuals________, and provide specific details for each employee, or dependent or COBRA continuee in the space provided on the following page.

5. Are there any dependents of employees who are currently disabled or in the hospital? ❒ **Yes** ❒ **No**

• ***If you answered "Yes" to any of the above questions, please complete the information on the following page.***

Question # (from previous page)	Name of Employee, Dependent or COBRA Continuant (Please specify)	Last 12 Months Medical Expenses	Diagnosis or Reason	Prognosis
		$		
		$		
		$		
		$		
		$		

The undersigned authorized officer of the Company hereby confirms that the Large Claim and Medical History Data disclosed in Section V is true and correct. The undersigned acknowledges that Oxford will rely on the information contained in this Section V in determining whether to offer coverage to the Company. The Company hereby acknowledges that if Oxford determines at any time that the information provided by the Company in the Section V contains a material misstatement or omission which the Company knew of or should have known of based on its personnel records and medical claims records, then Oxford shall, at any time, have the right in its sole discretion to (i) increase the rate of monthly premiums payable by the Company upon 30 days advance written notice or (ii) cancel coverage provided to the Company upon 60 days advance written notice.

____

Name of Company

X____

Signature of Authorized Officer of Company — Date

V. UNDERWRITING GUIDELINES

The following underwriting guidelines must be met for Oxford to accept this Application:

- The effective date of coverage is the 1st of each month. Renewal dates will always be the 1st of the month.
- The company must have been in business for 24 consecutive months prior to the requested effective date.
- The employer must contribute at least 50% towards total premium and be no less favorable than those applied to competitor plan options (if applicable).
- No more than 30% of the enrolling population can reside outside of the Oxford service area.
- No more than 10% of the enrolling population can be enrolled under a COBRA or state continuation plan.
- No more than 5% of the enrolled employees can be retirees under age 65 and no more than 10% of the enrolled employees can be retirees over age 65.
- The employer must have a minimum of 75% of the total eligible employees participate net of spousal waivers.
- Groups may have one or two plan design options available for the in-area population and one plan design option (Oxford USA) for the out-of-area population except for groups utilizing the Oxford Consumer Options Suite[SM](available to groups with 51 to 99 lives). These groups may select up to three plan designs for the in-area population and one plan design option (Oxford USA) for the out-of-area population.
- Request for Quote sheets should be submitted to your Oxford sales representative a minimum of 30 days prior to the requested effective date.
- Rates are subject to change based on final enrollment.

The undersigned authorized officer of the Company hereby confirms that the Company satisfies, and if this Application is accepted by Oxford, will continue to satisfy and remain in compliance with the foregoing underwriting guidelines set forth in this Section. The Company hereby acknowledges that if at any time it is not in compliance with the foregoing underwriting guidelines or if any census data provided by the Company to Oxford, in conjunction with this Application for coverage do not accurately reflect, in the judgment of Oxford, the actual Company member covered by Oxford, on the date coverage by Oxford first commences, then Oxford shall have the right, at any time upon 30 days written notice to the Company, to increase the monthly premium payable by the Company in such amount as is determined by Oxford, in its absolute discretion, to reflect the increased risk of such non-compliance or census variance.

____

Name of Company

X____

Signature of Authorized Officer of Company — Title of Authorized Officer of Company — Date

VI. COMPANY 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.

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.

Note: If applying for Freedom Plan, Liberty Plan, Freedom Plan Select or Liberty Plan Select coverage, please sign on both signature lines.
If applying for HMO or Liberty Plan (HMO Only) coverage, please only sign the first signature line.

Dated at:____________________ this____________________ day of________________________ 20________.

- **Application for HMO coverage: Oxford Health Plans (NY), Inc.**

X

Signature of Authorized Officer of the Company | Title of Officer of Company

Witness | Duly Licensed Resident Agent/Broker

- **Application for indemnity coverage: Oxford Health Insurance, Inc.**

X

Signature of Authorized Officer of the Company | Title of Officer of Company

Witness | Duly Licensed Resident Agent/Broker

Oxford Health Plans (NY), Inc.
Oxford Health Insurance, Inc.
48 Monroe Turnpike, Trumbull, CT 06611