

15. **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 of eligible employees in this company	Number of eligible employees to be insured

16. **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

II. SPECIFICATIONS FOR COVERAGE

PLEASE SELECT A PLAN FROM SECTION 1, 2 OR 3.

SECTION 1: FREEDOM PLAN & LIBERTY PLAN **PRODUCT** PPO POS **NETWORK** Freedom Liberty

NOTE: Not all plan combinations are available. Please refer to the rate model or contact your Sales Representative to verify the plan combination you selected is available.

Options	<input type="checkbox"/> Plan C	<input type="checkbox"/> Plan D
Office Copayment	<input type="checkbox"/> \$5 <input type="checkbox"/> \$10 <input type="checkbox"/> \$15 <input type="checkbox"/> \$15/\$25 <input type="checkbox"/> \$20 <input type="checkbox"/> \$25/\$40 <input type="checkbox"/> \$30 <input type="checkbox"/> \$40 <input type="checkbox"/> \$50	<input type="checkbox"/> \$5 <input type="checkbox"/> \$10 <input type="checkbox"/> \$15 <input type="checkbox"/> \$20
In-Network Coinsurance	<input type="checkbox"/> 80% <input type="checkbox"/> 90% <input type="checkbox"/> 100%	<input type="checkbox"/> 90% <input type="checkbox"/> 100%
Out-Of-Network Deductible	<input type="checkbox"/> \$200 <input type="checkbox"/> \$250 <input type="checkbox"/> \$300 <input type="checkbox"/> \$500 <input type="checkbox"/> \$750 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$3,000 <input type="checkbox"/> \$3,500	<input type="checkbox"/> \$200 <input type="checkbox"/> \$250 <input type="checkbox"/> \$300 <input type="checkbox"/> \$500 <input type="checkbox"/> \$750 <input type="checkbox"/> \$1,000
Maximum-Out-of-Pocket	<input type="checkbox"/> \$5,000 <input type="checkbox"/> \$8,333 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$25,000	<input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000

OPTIONS:

- Physician Visits for Preventive Care at no charge
- Hospital Confinement at no charge
- Physical Therapy 90 Rider
- Vision Care Rider
- Enhanced Dental Rider
- Premium Dental Rider
- Domestic Partner

PRESCRIPTION DRUG BENEFITS

Copayment Information: Base Plan (Out-of-Network Deductible and Coinsurance)
 Standard (Plan Copayment)

Optional Riders (Tier 1/ Tier 2/ Tier 3 Copayment) \$5/\$15/\$50* \$7/\$20/\$50* \$7/\$15/\$25 \$7/\$15/\$35*
 \$10/\$25/\$50* \$15/50%* \$15/\$30/\$60** (\$3,000 max) \$15/\$35/\$75*

*Pharmacy Deductible (applies to Tier 2 and Tier 3 drugs): None \$50 \$100** (mandatory for \$15/\$30/\$60)

Oral Contraceptives: Yes No (Qualified State Exempt Groups Only)

SECTION 2: Freedom Plan Direct Liberty Plan Direct

Options	<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	<input type="checkbox"/> Plan 7	<input type="checkbox"/> Plan 8	<input type="checkbox"/> Plan 9	<input type="checkbox"/> Plan 10	<input type="checkbox"/> Plan 11
Copayment	\$15 PCP / \$25 Specialist	\$25 PCP / \$40 Specialist	\$25 PCP / \$40 Specialist	N/A	N/A	N/A	\$15 PCP / \$25 Specialist	\$25 PCP / \$40 Specialist	\$25 PCP / \$40 Specialist	\$30 PCP / \$50 Specialist	\$30 PCP / \$50 Specialist
Single Deductible*	\$500 / \$1,000	\$500 / \$1,000	\$1,000 / \$2,000	\$500 / \$1,000	\$2,000 / \$2,000	\$1,000 / \$2,000	\$1,000 / \$2,000	\$500 / \$1,000	\$1,000 / \$2,000	\$1,500 / \$2,000	\$2,500 / \$2,500
Family Deductible*	\$1,000 / \$2,000	\$1,000 / \$2,000	\$2,000 / \$4,000	\$1,000 / \$2,000	\$4,000 / \$4,000	\$2,000 / \$4,000	\$2,000 / \$4,000	\$1,000 / \$2,000	\$2,000 / \$4,000	\$3,000 / \$4,000	\$5,000 / \$5,000
Coinsurance*	90%/70%	80%/60%	80%/60%	90%/70%	90%/70%	80%/60%	100%/70%	100%/70%	100%/70%	80%/60%	80%/60%
Single Max Out-of-Pocket	\$1,500 / \$4,000	\$2,500 / \$5,000	\$3,000 / \$6,000	\$1,500 / \$4,000	\$3,000 / \$5,000	\$3,000 / \$6,000	\$1,000 / \$5,000	\$500 / \$4,000	\$1,000 / \$5,000	\$3,500 / \$6,000	\$4,500 / \$6,500
Family Max Out-of-Pocket	\$3,000 / \$8,000	\$5,000 / \$10,000	\$6,000 / \$12,000	\$3,000 / \$8,000	\$6,000 / \$10,000	\$6,000 / \$12,000	\$2,000 / \$10,000	\$1,000 / \$8,000	\$2,000 / \$10,000	\$7,000 / \$12,000	\$9,000 / \$13,000

*In-network/Out-of-Network

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

DIRECT OPTIONS:

- Vision Care Rider Premium Dental Rider Enhanced Dental Rider Domestic Partner

PRESCRIPTION DRUG BENEFITS

- Base Plan (Out of Network Deductible and Coinsurance)
 Plan Copayment (Available only with office visit Copayment plans)

Optional Riders (Tier 1/ Tier 2/ Tier 3 Copayment)

- \$7/\$15/\$25 \$10/\$25/\$50* \$15/50%* \$5/\$15/\$50*
 \$7/\$20/\$50* \$7/\$15/\$35* \$15/\$30/\$60** (\$3,000 max) \$15/\$35/\$75*

*Pharmacy Deductible (applies to Tier 2 and Tier 3 drugs): None \$50 \$100** (mandatory for \$15/\$30/\$60) _____

Oral Contraceptives: Yes No (Qualified State Exempt Groups Only)

SECTION 3: OXFORD MyPLAN

Note: Groups enrolling in the Oxford MyPlan must also fill out an Oxford MyPlan Health Reserve Account Group Application (Form #6740).

HEALTH BENEFITS:

- Freedom Network Liberty Network

OXFORD MYPLAN OPTIONS (ALL INFORMATION IS SUBJECT TO HOME OFFICE APPROVAL)

Options	<input type="checkbox"/> Plan 1	<input type="checkbox"/> Plan 2	<input type="checkbox"/> Plan3
Copayment	\$25/\$40	N/A	N/A
Single Deductible (In-network/Out-of-network)	\$1,000/\$2,000	\$2,000/\$2,000	\$1,000/\$2,000
Family Deductible (In-network/Out-of-network)	\$2,000/\$4,000	\$4,000/\$4,000	\$2,000/\$4,000
Coinsurance (In-network/Out-of-network)	80%/60%	90%/70%	80%/60%
Single Out-of-Pocket Maximum (Family = 2x)	\$3,000/\$6,000	\$3,000/\$5,000	\$3,000/\$6,000

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

OXFORD MYPLAN OPTIONS (ALL INFORMATION IS SUBJECT TO HOME OFFICE APPROVAL)

- Vision Domestic Partner

PRESCRIPTION DRUG BENEFITS:

Prescription Drug Plan: Yes No

Copayment Information: Base Plan (Out of Network Deductible and Coinsurance)
 Standard (Plan Copayment) Available only with Plan #1.

Optional Riders (Tier 1/ Tier 2/ Tier 3 Copayment)

\$7/\$15/\$25 \$10/\$25/\$50* \$15/50%* \$15/\$35/\$75*

*Pharmacy Deductible (applies to Tier 2 and Tier 3 drugs): None \$50 \$100

Oral Contraceptives: Yes No (Qualified State Exempt Groups Only)

SECTION 4: OXFORD HSA DIRECT

Note: Groups enrolling in the Oxford HSA Direct are required to fill out a Certificate of Understanding Form (#8766). For groups electing to use OptumHealthBank, an Oxford HSA Employer Notification Form (#7423) must be completed.

HEALTH BENEFITS: Freedom Network Liberty Network

Options	<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
Single Deductible** (In-network/Out-of-network)	\$1,250/\$2,000	\$2,000/\$2,000	\$2,500/\$2,500	\$1,250/\$2,000	\$2,000/\$2,000	\$2,500/\$2,500
Family Deductible** (In-network/Out-of-network)	\$2,500/\$4,000	\$4,000/\$4,000	\$5,000/\$5,000	\$2,500/\$4,000	\$4,000/\$4,000	\$5,000/\$5,000
Coinsurance (In-network/Out-of-network)	80%/60%	90%/70%	90%/70%	100%/70%	100%/70%	100%/70%
Single Medical Out-of-pocket Maximum (In-network/Out-of-network) (Family = 2x)	\$3,250/\$6,000	\$3,000/\$5,000	\$3,500/\$5,500	\$1,250/\$5,000	\$2,000/\$5,000	\$2,500/\$5,500

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

PRESCRIPTION DRUG BENEFITS: (REQUIRED)**

(Tier 1/ Tier2/ Tier 3 Copayment)

\$7/\$15/\$35 \$10/\$25/\$50 \$15/50%

Oral Contraceptives: Yes No (Qualified State Exempt Groups Only)

****NOTE:** As of April 1, 2005, all in-network medical and pharmacy services are subject to the in-network deductible. Once the deductible has been satisfied, the applicable medical coinsurance and prescription drug copayment will apply based on the option selected at plan inception. Out-of-network benefits are accumulated separately. No individual on a multiple person contract may satisfy the individual deductible and maximum out-of-pocket until the entire family deductible or maximum out-of-pocket have been met.

OXFORD HSA DIRECT OPTIONS (ALL INFORMATION IS SUBJECT TO HOME OFFICE APPROVAL)

- Vision Domestic Partner
 Premium Dental Rider Physical Therapy 90 Rider (30 visits standard)
 Enhanced Dental Rider

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)

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 POS
 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

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.

8. Does the employer participate in an arrangement with a Professional Employer Organization? Yes No
 (Refer to Advisory Bulletin 00-SEH-02 if you need information concerning what constitutes a Professional Employer Organization.)

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 retiree's 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 to make or modify any request or application for insurance or to bind Oxford 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. 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 _____

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.

Print Name of Officer, Partner or Proprietor

Signature of Officer, Partner or Proprietor

Witness to Signature