

# New York Member Enrollment Form – OHI

**MAILING ADDRESS:** P. O. Box 7085, Bridgeport CT 06601 • 1-800-444-6222 • [www.oxfordhealth.com](http://www.oxfordhealth.com)











THANK YOU FOR CHOOSING AN OXFORD PRODUCT  
FOR YOU AND YOUR FAMILY.

## **IMPORTANT:**

**PLEASE PRINT AND PRESS DOWN FIRMLY WHEN COMPLETING THIS FORM.  
IN ORDER TO PROCESS THE ATTACHED FORM AND BEGIN COVERAGE,  
ALL FIELDS MUST BE COMPLETED ACCURATELY AND IN ITS ENTIRETY.**

## **BE SURE TO:**

-  Use only blue or black ballpoint pen
-  Enter all dates using the MM/DD/YYYY format
-  Employer and employee signatures are required
-  List any coordinating coverage (coverage in addition to this coverage)
-  List any coverage you had prior to this coverage
-  Attach disability paperwork, if applicable
-  Check "full-time student" in the child column if the child is between the ages of 19-23 and a full-time student at an accredited institution
-  Submit this form within 31 days of the requested effective date or within 60 days of the qualifying event for COBRA or State Continuation

IF YOU HAVE ANY QUESTIONS,  
PLEASE FEEL FREE TO CALL CUSTOMER SERVICE AT  
**1-800-444-6222**

# New York Member Enrollment Form – OHI



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A. Group Information (To be completed by the employer)				Please print neatly using black or blue ballpoint pen • ALL DATES MUST BE: MM/DD/YYYY			
Group Number	Group Name	Plan CSP	Billing Group	Date of Hire / /	Effective Date / /	Occupation	
<input type="checkbox"/> On Leave of Absence	<input type="checkbox"/> Retired	COBRA/SC Qualifying Event		Event Date / /	<b>Employer Signature</b> X		Date / /
<input type="checkbox"/> Union Employee	<input type="checkbox"/> Disabled						
B. Applicant Details (To be completed by the employee)		Employee/Subscriber	Spouse	Child	Child		
Social Security Number:							
Last Name:							
First Name, Middle Initial:							
Date of Birth: (MM/DD/YYYY)		/ /	/ /	/ /	/ /		
Gender and Disability Status: (Check appropriate boxes.)		<input type="checkbox"/> M <input type="checkbox"/> F / <input type="checkbox"/> Disabled	<input type="checkbox"/> M <input type="checkbox"/> F / <input type="checkbox"/> Disabled	<input type="checkbox"/> M <input type="checkbox"/> F / <input type="checkbox"/> Disabled	<input type="checkbox"/> M <input type="checkbox"/> F / <input type="checkbox"/> Disabled	<input type="checkbox"/> M <input type="checkbox"/> F / <input type="checkbox"/> Disabled	
Primary Care Physician (PCP) ID Number:							
PCP Name: (If an existing patient of PCP, check "Yes".)		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	
Check all that apply:			<input type="checkbox"/> Domestic Partner	<input type="checkbox"/> Full-time Student	<input type="checkbox"/> Full-time Student		
Prior Carrier (List coverage prior to this.)		Carrier: Policy Number: From Date Thru date::					
<input type="checkbox"/> Same for all		/ / / /	/ / / /	/ / / /	/ / / /		
C. Coordination of Benefits		Employee/Subscriber	Spouse	Child	Child		
Medicare Coverage	Check appropriate box and list effective date:	<input type="checkbox"/> Part A / / <input type="checkbox"/> Part B / / <input type="checkbox"/> Part D / /	<input type="checkbox"/> Part A / / <input type="checkbox"/> Part B / / <input type="checkbox"/> Part D / /	<input type="checkbox"/> Part A / / <input type="checkbox"/> Part B / / <input type="checkbox"/> Part D / /	<input type="checkbox"/> Part A / / <input type="checkbox"/> Part B / / <input type="checkbox"/> Part D / /		
Pharmacy	Policy Number: Carrier: Policy Holder: Group Number:						
<input type="checkbox"/> Same for all	Effective Date: / /	BIN: PCN:	BIN: PCN:	BIN: PCN:	BIN: PCN:		
Medical	Policy Number: Carrier: Policy Holder: Effective Date:						
<input type="checkbox"/> Same for all		/ /	/ /	/ /	/ /		
<p>I understand that my enrollments and benefits are in accordance with those described in the Oxford Health Insurance Certificate. I understand that, in order to receive in-network benefits, I and any enrolled dependents must seek care through our Oxford affiliated primary care physician or through an Oxford-affiliated specialist physician with an authorized referral from the primary care physician if required. I further understand that if I do not adhere to these requirements, I will be eligible only for out-of-network health insurance coverage under the terms of the Certificate. 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, or conceals for the purpose of misleading, 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 five thousand dollars and the stated value of the claim for each such violation. I authorize any health provider or insurer to furnish Oxford any records concerning me or any enrolled member of my family for whom information is requested.</p>							
Employee's Address (Apt #)				Employee's Signature			
City				Date			
State		Zip		X / /			

# NY Small Group Application – OHI

Oxford Health Insurance Inc. • www.oxfordhealth.com

Mailing Address: Group Enrollment Department, 14 Central Park Drive, Hooksett, NH 03106

## 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 code

d. Phone Number     Ext.

e. Fax Number

f. E-mail Address

g. Add'l Contact & Number

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

a. Name

b. Title

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

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 of Coverage.

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:** If the initial effective date is the 15<sup>th</sup> of the month, then the anniversary date is the first of the month following the effective date month.
3. **Open enrollment period:** The open enrollment period is the month prior to your anniversary date. The open enrollment effective date is the first of the month following the period.
4. **Total Number of Employees:** \_\_\_\_\_
5. **Employee Eligibility:** All full-time, permanent employees who work at least \_\_\_\_\_ hours per week (minimum 20 hours/week) are eligible.
6. **Number of Current Eligible Employees:** \_\_\_\_\_
7. **Number of Employees** enrolling with Oxford 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? \_\_\_\_\_

10. **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

**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).

11. **Integration with Medicare Benefits:** Health Benefits covered by Medicare Part A and B are carved out for Retired Employees age 65 or over and their dependents age 65 or over if the group offers retiree coverage.

### CLASS I

**Definition of Class I** \_\_\_\_\_

**i) Eligibility/Termination**

Date on which the employee completes \_\_\_\_\_ days/months (circle one) of continuous service.

Termination will be the date of termination of employment.

**ii) Eligibility/Termination**

On the first day of the calendar month coinciding with or next following the date on which the employee completes \_\_\_\_\_ days/months (circle one) of continuous service.

Termination will be on the last day of the calendar month.

**iii) Waiting Period for Rehires**

Waiting Period Waived for Rehires?  Yes  No

If yes, waived if rehired within \_\_\_\_\_ months.

### CLASS II

**Definition of Class II** \_\_\_\_\_

**i) Eligibility/Termination**

Date on which the employee completes \_\_\_\_\_ days/months (circle one) of continuous service.

Termination will be the date of termination of employment.

**ii) Eligibility/Termination**

On the first day of the calendar month coinciding with or next following the date on which the employee completes \_\_\_\_\_ days/months (circle one) of continuous service.

Termination will be on the last day of the calendar month.

**iii) Waiting Period for Rehires**

Waiting Period Waived for Rehires?  Yes  No

If yes, waived if rehired within \_\_\_\_\_ months.

# II. ADMINISTRATIVE INFORMATION (CONTINUED)

## CLASS III

Definition of Class III \_\_\_\_\_

**i) Eligibility/Termination**

Date on which the employee completes \_\_\_\_\_ days/months (circle one) of continuous service.

Termination will be the date of termination of employment.

**ii) Eligibility/Termination**

On the first day of the calendar month coinciding with or next following the date on which the employee completes \_\_\_\_\_ days/months (circle one) of continuous service.

Termination will be on the last day of the calendar month.

**iii) Waiting Period for Rehires**

Waiting Period Waived for Rehires?  Yes  No

If yes, waived if rehired within \_\_\_\_\_ months.

## CLASS V

Definition of Class V \_\_\_\_\_

**i) Eligibility/Termination**

Date on which the employee completes \_\_\_\_\_ days/months (circle one) of continuous service.

Termination will be the date of termination of employment.

**ii) Eligibility/Termination**

On the first day of the calendar month coinciding with or next following the date on which the employee completes \_\_\_\_\_ days/months (circle one) of continuous service.

Termination will be on the last day of the calendar month.

**iii) Waiting Period for Rehires**

Waiting Period Waived for Rehires?  Yes  No

If yes, waived if rehired within \_\_\_\_\_ months.

## CLASS IV

Definition of Class IV \_\_\_\_\_

**i) Eligibility/Termination**

Date on which the employee completes \_\_\_\_\_ days/months (circle one) of continuous service.

Termination will be the date of termination of employment.

**ii) Eligibility/Termination**

On the first day of the calendar month coinciding with or next following the date on which the employee completes \_\_\_\_\_ days/months (circle one) of continuous service.

Termination will be on the last day of the calendar month.

**iii) Waiting Period for Rehires**

Waiting Period Waived for Rehires?  Yes  No

If yes, waived if rehired within \_\_\_\_\_ months.

## CLASS VI

Definition of Class VI \_\_\_\_\_

**i) Eligibility/Termination**

Date on which the employee completes \_\_\_\_\_ days/months (circle one) of continuous service.

Termination will be the date of termination of employment.

**ii) Eligibility/Termination**

On the first day of the calendar month coinciding with or next following the date on which the employee completes \_\_\_\_\_ days/months (circle one) of continuous service.

Termination will be on the last day of the calendar month.

**iii) Waiting Period for Rehires**

Waiting Period Waived for Rehires?  Yes  No

If yes, waived if rehired within \_\_\_\_\_ months.

# III. PRODUCT AND PLAN DESIGNS

## A. Oxford Plan Metro

Referrals are required for these plan designs.

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

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% of Medicare rate <input type="checkbox"/> 70% UCR	<input type="checkbox"/> 150% of Medicare rate <input type="checkbox"/> 70% UCR
<b>Inpatient/Outpatient Facility Copayment</b>	\$100 per continuous confinement (Inpatient/Outpatient)	\$250 per day up to five days Inpatient (\$1,250 max. copayment per year) / \$250 Outpatient	\$500 Inpatient/ \$150 Outpatient	\$350 per day up to five days Inpatient (\$1,750 max. copayment per year) / \$250 Outpatient	\$100 per continuous confinement (Inpatient/Outpatient)	\$250 per day up to five days Inpatient (\$1,250 maximum copayment per year) / \$250 Outpatient

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

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

Additional Benefit Options:

- Vision       Dental Enhanced       Dental Premium       Other: \_\_\_\_\_  
 Age 25 Dependent Student Cutoff (Age 23 is standard)  
**Note:** Cutoff must match for all plan designs selected.  
 Domestic Partner  
 Coverage for Biologically Based Mental Illness and Children with Serious Emotional Disturbances

Please select optional prescription drug coverage:

Options	Tier 1	Tier 2	Tier 3	Mail-Order	Deductible** (Please select one)
<input type="checkbox"/> Option 1	\$10 copayment	\$25 copayment	\$50 copayment	2x copayment	<input type="checkbox"/> \$50 <input type="checkbox"/> \$100 <input type="checkbox"/> \$250 <input type="checkbox"/> \$500
<input type="checkbox"/> Option 2	\$15 copayment	50%	50%	2x copayment or 50%	<input type="checkbox"/> \$50 <input type="checkbox"/> \$100 <input type="checkbox"/> \$250 <input type="checkbox"/> \$500
<input type="checkbox"/> Option 3*	\$15 copayment	\$30 copayment	\$60 copayment	\$30/\$60/\$180	\$100 (Required)
<input type="checkbox"/> Waived Coverage	N/A	N/A	N/A	N/A	N/A

\*This pharmacy plan has a maximum per contract year of \$3,000, applicable to all drugs.

\*\*Deductible applies to Tier 2 and Tier 3 drugs.

Contraceptives:

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

Medicare Part D 28% Subsidy - For the prescription plan design above, do you currently participate or plan to participate with the 28% Government Subsidy for your Medicare eligible retirees?  Yes    No



# III. PRODUCT AND PLAN DESIGNS (CONTINUED)

## C. Oxford Exclusive Plan Metro (Non-gated - No referrals required)

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

Please Select Network:  Freedom  Liberty

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
<b>Copayment:</b> a. PCP b. Specialist	\$15 per visit \$30 per visit	\$25 per visit \$50 per visit	\$15 per visit \$30 per visit	\$25 per visit \$50 per visit	\$25 per visit \$50 per visit	\$20 per visit \$40 per visit
<b>Single Deductible</b>	none	none	\$1,000	\$1,000	\$2,000	N/A
<b>Family Deductible</b>	none	none	\$2,000	\$2,000	\$4,000	N/A
<b>Coinsurance</b>	none	none	80% to \$10,000/\$20,000	90% to \$10,000/\$20,000	90% to \$10,000/\$20,000	N/A
<b>Outpatient Facility Copayment</b>	\$150 per incident	\$300 per incident	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	\$200 per incident
<b>Inpatient Facility Copayment</b>	\$150 per continuous confinement	\$300 per day to five day maximum	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	\$200 per continuous confinement
<b>Emergency Room</b>	\$75	\$75	\$75	\$75	\$75	\$75

Deductibles and out-of-pocket accumulation periods are on a  calendar year  contract year basis (plans 3-5 only).

**Additional Benefit Options:**  Vision  Dental Enhanced  Dental Premium  Other: \_\_\_\_\_  
 Age 25 Dependent Student Cutoff (Age 23 is standard) Subject to Home Office Approval  
**Note:** Cutoff must match for all plan designs selected  
 Domestic Partner  
 Coverage for Biologically Based Mental Illness and Children with Serious Emotional Disturbances

Please select optional prescription drug coverage:

Options	Tier 1	Tier 2	Tier 3	Mail-Order	Deductible** (Please select one)
<input type="checkbox"/> Option 1	\$10 copayment	\$25 copayment	\$50 copayment	2x copayment	<input type="checkbox"/> \$50 <input type="checkbox"/> \$100
<input type="checkbox"/> Option 2	\$15 copayment	50%	50%	2x copayment or 50%	<input type="checkbox"/> \$50 <input type="checkbox"/> \$100
<input type="checkbox"/> Option 3*	\$15 copayment	\$30 copayment	\$60 copayment	\$30/\$60/\$180	\$100 (Required)
<input type="checkbox"/> Option 4	\$15 copayment	\$35 copayment	\$75 copayment	2x copayment	<input type="checkbox"/> \$50 <input type="checkbox"/> \$100
<input type="checkbox"/> Waived Coverage	N/A	N/A	N/A	N/A	N/A

\*This pharmacy plan has a maximum per contract year of \$3,000, applicable to all drugs.

\*\*Deductible applies to Tier 2 and Tier 3 drugs.

Contraceptives:

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

Medicare Part D 28% Subsidy - For the prescription plan design above, do you currently participate or plan to participate with the 28% Government Subsidy for your Medicare eligible retirees?  Yes  No

**D. Oxford Ease (Non-gated – No referrals required)**

Please Select Network:  Freedom  Liberty

Option	<input type="checkbox"/> Plan 1
Copayment: a. PCP b. Specialist	\$50 per visit \$50 per visit
Single Deductible	N/A
Family Deductible	N/A
Coinsurance	N/A
Outpatient Facility Copayment	\$500 per incident
Inpatient Facility Copayment	\$500 per day, up to a maximum of \$2,500 per calendar year
Emergency Room	\$150

Additional Benefit Options:  Vision  Dental Enhanced  Dental Premium  Other: \_\_\_\_\_  
 Age 25 Dependent Student Cutoff (Age 23 is standard) Subject to Home Office Approval  
**Note:** Cutoff must match for all plan designs selected  
 Domestic Partner  
 Coverage for Biologically Based Mental Illness and Children with Serious Emotional Disturbances

Please select optional prescription drug coverage:

Options	Tier 1	Tier 2	Tier 3	Mail-Order	Deductible* (Please select one)
<input type="checkbox"/> Option 1	\$15 copayment	\$35 copayment	\$75 copayment	2x copayment	<input type="checkbox"/> \$50 <input type="checkbox"/> \$100
<input type="checkbox"/> Waived Coverage	N/A	N/A	N/A	N/A	N/A

\*Deductible applies to Tier 2 and Tier 3 drugs.

Contraceptives:

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

Medicare Part D 28% Subsidy – For the prescription plan design above, do you currently participate or plan to participate with the 28% Government Subsidy for your Medicare eligible retirees?  Yes  No

# III. PRODUCT AND PLAN DESIGNS (CONTINUED)

## E. Freedom Plan Direct and Liberty Plan Direct

No referrals are required for these plan designs.

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

Please Select Network:  Freedom  Liberty

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
<b>Copayment</b>	\$15 PCP / \$25 Specialist	\$25 PCP / \$40 Specialist	\$25 PCP / \$40 Specialist	\$30 PCP / \$50 Specialist	N/A	N/A	N/A	\$15 PCP / \$25 Specialist	\$25 PCP / \$40 Specialist	\$25 PCP / \$40 Specialist
<b>Single Deductible</b>	\$500/\$1,000	\$500/\$1,000	\$1,000/\$2,000	\$2,000/\$2,000	\$500/\$1,000	\$2,000/\$2,000	\$1,000/\$2,000	\$1,000/\$2,000	\$500/\$1,000	\$1,000/\$2,000
<b>Family Deductible</b>	\$1,000/\$2,000	\$1,000/\$2,000	\$2,000/\$4,000	\$4,000/\$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
<b>Coinsurance</b>	90%/70%	80%/60%	80%/60%	80%/60%	90%/70%	90%/70%	80%/60%	100%/70%	100%/70%	100%/70%
<b>Out-of-Network</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% 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% of Medicare rate / <input type="checkbox"/> 70% UCR	<input type="checkbox"/> 150% of Medicare rate / <input type="checkbox"/> 70% UCR
<b>Single Maximum Out-of-Pocket</b>	\$1,500/\$4,000	\$2,500/\$5,000	\$3,000/\$6,000	\$4,000/\$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
<b>Family Maximum Out-of-Pocket</b>	\$3,000/\$8,000	\$5,000/\$10,000	\$6,000/\$12,000	\$8,000/\$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

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

**Additional Benefit Options:**

- Vision     
  Dental Enhanced     
  Dental Premium     
  Other: \_\_\_\_\_
- Age 25 Dependent Student Cutoff (Age 23 is standard)
- SUBJECT TO HOME OFFICE APPROVAL
- Note:** Cutoff must match for all plan designs selected.
- Domestic Partner
- Coverage for Biologically Based Mental Illness and Children with Serious Emotional Disturbances

**Please select optional prescription drug coverage:**

Options	Tier 1	Tier 2	Tier 3	Mail-Order	Deductible** (Please select one)
<input type="checkbox"/> Option 1	\$10 copayment	\$25 copayment	\$50 copayment	2x copayment	<input type="checkbox"/> \$50 <input type="checkbox"/> \$100 <input type="checkbox"/> \$150 <input type="checkbox"/> \$250
<input type="checkbox"/> Option 2	\$15 copayment	50%	50%	2x copayment or 50%	<input type="checkbox"/> \$50 <input type="checkbox"/> \$100 <input type="checkbox"/> \$150 <input type="checkbox"/> \$250
<input type="checkbox"/> Option 3*	\$15 copayment	\$30 copayment	\$60 copayment	\$30/\$60/\$180	\$100 (Required)
<input type="checkbox"/> Waived Coverage	N/A	N/A	N/A	N/A	N/A

\*This pharmacy plan has a maximum per contract year of \$3,000, applicable to all drugs.

\*\*Deductible applies to Tier 2 and Tier 3 drugs.

Contraceptives:

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

Medicare Part D 28% Subsidy - For the prescription plan design above, do you currently participate or plan to participate with the 28% Government Subsidy for your Medicare eligible retirees?  Yes  No

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

#### F. Oxford MyPlan

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

Please Select Network:  Freedom  Liberty

No referrals are required for these plan designs.

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

Please select a plan type:

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

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

Additional Benefit Options:

Vision  Dental Enhanced  Dental Premium

Age 25 Dependent Student Cutoff (Age 23 is standard)

**Note:** Cutoff must match for all plan designs selected.

Domestic Partner

Coverage for Biologically Based Mental Illness and Children with Serious Emotional Disturbances

Please select optional prescription drug coverage:

Options	Tier 1	Tier 2	Tier 3	Mail-Order	Deductible** (Please select one)
<input type="checkbox"/> Option 1	\$10 copayment	\$25 copayment	\$50 copayment	2x copayment	\$50 (Required)
<input type="checkbox"/> Option 2	\$15 copayment	50%	50%	2x copayment or 50%	\$50 (Required)
<input type="checkbox"/> Option 3*	\$15 copayment	\$30 copayment	\$60 copayment	\$30/\$60/\$180	\$100 (Required)
<input type="checkbox"/> Waived Coverage	N/A	N/A	N/A	N/A	N/A

\*This pharmacy plan has a maximum per contract year of \$3,000, applicable to all drugs.

\*\* Deductible applies to Tier 2 and Tier 3 drugs.

Contraceptives:

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

Medicare Part D 28% Subsidy - For the prescription plan design above, do you currently participate or plan to participate with the 28% Government Subsidy for your Medicare eligible retirees?  Yes  No

**G. Oxford HSA Exclusive**

**Please note:** Groups enrolling in the Oxford HSA Exclusive must also fill out an Oxford HSA Notification Form (#7423).

**Please Select Network:**  Freedom  Liberty

No referrals are required for these plan designs.

**In-Network Only**

Options	<input type="checkbox"/> Plan 1	<input type="checkbox"/> Plan 2	<input type="checkbox"/> Plan 3
Single Deductible**	\$1,250	\$2,000	\$2,850
Family Deductible**	\$2,500	\$4,000	\$5,700
Coinsurance	100%	100%	100%
Single Medical Maximum Out-of-Pocket	\$1,250	\$2,000	\$2,850
Family Medical Maximum Out-of-Pocket	\$2,500	\$4,000	\$5,700

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

Please select prescription drug coverage\*\* (Required):

Options	Tier 1	Tier 2	Tier 3	Mail-Order
<input type="checkbox"/> Option 1	\$10 copayment	\$25 copayment	\$50 copayment	2x copayment
<input type="checkbox"/> Option 2	\$15 copayment	50%	50%	2x copayment or 50%

Contraceptives:

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

**\*\*NOTE:** 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. 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. Out-of-network benefits are accumulated separately.

Medicare Part D 28% Subsidy - For the prescription plan design above, do you currently participate or plan to participate with the 28% Government Subsidy for your Medicare eligible retirees?  Yes  No

**Additional Benefit Options:**

- Vision  Dental Enhanced  Dental Premium  Other: \_\_\_\_\_
- Age 25 Dependent Student Cutoff (Age 23 is standard)
- Note:** Cutoff must match for all plan designs selected
- Domestic Partner
- Coverage for Biologically Based Mental Illness and Children with Serious Emotional Disturbances

SUBJECT TO HOME OFFICE APPROVAL

# III. PRODUCT AND PLAN DESIGNS (CONTINUED)

## H. Oxford HSA Direct

**Please note:** Groups enrolling in the Oxford HSA Direct must also fill out an Oxford HSA Notification Form (#7423).

**Please Select Network:**  Freedom  Liberty

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	<input type="checkbox"/> Plan 4	<input type="checkbox"/> Plan 5	<input type="checkbox"/> Plan 6
<b>Single Deductible**</b>	\$1,250/ \$2,000	\$2,000/ \$2,000	\$2,850/ \$2,850	\$1,250/ \$2,000	\$2,000/ \$2,000	\$2,850/ \$2,850
<b>Family Deductible**</b>	\$2,500/ \$4,000	\$4,000/ \$4,000	\$5,700/ \$5,700	\$2,500/ \$4,000	\$4,000/ \$4,000	\$5,700/ \$5,700
<b>Coinsurance</b>	80%/60%	90%/70%	90%/70%	100%/70%	100%/70%	100%/70%
<b>Single Medical Maximum Out-of-Pocket</b>	\$3,250/ \$6,000	\$3,000/ \$5,000	\$3,850/ \$5,850	\$1,250/ \$5,000	\$2,000/ \$5,000	\$2,850/ \$5,850
<b>Family Medical Maximum Out-of-Pocket</b>	\$6,500/ \$12,000	\$6,000/ \$10,000	\$7,700/ \$11,700	\$2,500/ \$10,000	\$4,000/ \$10,000	\$5,700/ \$11,700

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

**Additional Benefit Options:**

- Vision  Dental Enhanced  Dental Premium  Other: \_\_\_\_\_
- Age 25 Dependent Student Cutoff (Age 23 is standard) SUBJECT TO HOME OFFICE APPROVAL
- Note:** Cutoff must match for all plan designs selected.
- Domestic Partner
- Coverage for Biologically Based Mental Illness and Children with Serious Emotional Disturbances

**Please select optional prescription drug coverage\*\* (Required):**

Options	Tier 1	Tier 2	Tier 3	Mail-Order
<input type="checkbox"/> Option 1	\$10 copayment	\$25 copayment	\$50 copayment	2x copayment
<input type="checkbox"/> Option 2	\$15 copayment	50%	50%	2x copayment or 50%

Contraceptives:

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

**\*\*NOTE:** 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.

Medicare Part D 28% Subsidy - For the prescription plan design above, do you currently participate or plan to participate with the 28% Government Subsidy for your Medicare eligible retirees?  Yes  No

## IV. RATE INFORMATION

**Monthly Rates:** All new groups are subject to the four-tier rate structure indicated below. Rates must be included in the spaces below for application processing. Please note: All four categories must be completed.

<b>Single</b>	<b>Couple</b>	<b>Parent/Children</b>	<b>Family</b>
\$	\$	\$	\$

## V. BROKER / AGENT INFORMATION

	Broker	Co-Broker	General Agent
1. Name of Payee:	Norman J. Michaels & Associates, Inc		
2. Payee's Oxford Broker Code (Required):	BC0138		
3. Payee's Social Security # or Federal Tax ID # :	13-3165414		
4. Name of Writing Agent (Required if Payee is a company):	Norman J. Michaels		
5. Writing Agent's Oxford Broker Code (Required if Payee is a company):			
6. Commission Split % :	100%		
7. Sales Representative:	Annamarie Cataquet		
Comments:			

**\*Important Information Regarding Producer Compensation:**

We pay brokers and agents (referred to collectively as "producers") compensation for their services in connection with the sale of our insured products in compliance with applicable law. We pay "base commissions" based on factors such as product type, amount of premium, group size and number of employees. These commissions are reflected in the premium rate. In addition, we may pay bonuses pursuant to bonus programs established from time to time which are designed to provide incentives to achieve production targets, persistency levels, growth goals or other objectives. Bonuses are not reflected in the premium rate but are paid from our general administrative expenses. It is our policy not to pay commissions to producers with respect to a product for which the customer is also paying the producer a commission or other fee. Please note we also may make payments from time to time to producers for services other than those relating to the sale of policies (for example, compensation for services as a general agent or as a consultant). Producer compensation is subject to disclosure of Schedule A of the ERISA Form 5500 for customers governed by ERISA and subject to form 5500 filing requirements. We have also taken steps to ensure that producers properly disclose their compensation arrangements to their customers, but we cannot guarantee the producer's compliance. For general information on our producer payment arrangements, please go to [www.oxfordhealth.com](http://www.oxfordhealth.com). For specific information about the compensation payable with respect to your particular policy, please contact your producer.

## VI. CONSENT

### AUTHORIZATION FOR BROKER TO ACT AS BENEFITS ADMINISTRATOR

The undersigned hereby requests Oxford 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 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 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. COBRA & EXTENSION OF BENEFITS DATA

1. Do you have any individuals currently on COBRA continuation?  Yes  No  
If yes, identify the number of individuals \_\_\_\_\_.
2. Are there any dependents of employees who are currently disabled or in the hospital?  Yes  No

What is the length of the prior carrier's extension of benefits period for disabled employees or dependents? \_\_\_\_\_

## VIII. 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.

**SIGN HERE**

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.

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, or conceals for the purpose of misleading, 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 such violation.

Oxford Health Insurance, Inc.

**SIGN HERE**

X

Signature of Authorized Officer of the Company

Title

Witness

Duly Licensed Resident Agent/Broker