

NY Sole Proprietor Application

Oxford Health Insurance Inc.

Mailing Address: Group Enrollment Department, 14 Central Park Drive, Hooksett, NH 03106 • www.oxfordhealth.com

I. GENERAL INFORMATION

1. **Full Legal Name of Group:** CHAMBER BENEFITS GROUP

2. **Primary Address of Group:**
(Street Address
 City, State, ZIP Code)
 *No P.O. Box

3. **Plan Administrator/Contact:**

a. Name: CHAMBER BENEFITS GROUP

b. Title:

c. Address (if different from primary)
 City, State, ZIP Code: 108 CORPORATE PARK DRIVE
 WHITE PLAINS NY 10604

d. Phone Number: 914 273 4723 Ext.

e. Fax Number: 914 273 4728

f. E-mail Address:

g. Add'l Contact & Number:

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

a. Name: TRISTATE SPECIAL MARKETING

b. Title:

c. Address (if different from primary)
 City, State, ZIP Code: 80 BUSINESS PARK DRIVE, SUITE 306
 ARMONK NY 10504

d. Phone Number: 914 273 4723 Ext.

e. Fax Number: 914 273 4728

5. **Nature of Business:**

6. **SIC Code:**

7. **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 1st or 15th / Year)
2. **Anniversary date:** If the initial effective date is the 15th 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:** 1
5. **Employee Eligibility:** All full-time, permanent employees who work at least 20 hours per week (minimum 20 hours/week) are eligible.
6. **Number of Current Eligible Employees:** 1
7. **Number of Employees** enrolling with Oxford with the new group application 1
8. **Number of Waivers** for health coverage submitted 0

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					
	<input checked="" type="checkbox"/> Plan 1	<input checked="" type="checkbox"/> Plan 2	<input type="checkbox"/> Plan 3	<input type="checkbox"/> Plan 4	<input type="checkbox"/> Plan 5	<input type="checkbox"/> Plan 6
Copayment:						
a. PCP	\$15 per visit	\$25 per visit	\$15 per visit	\$25 per visit	\$15 per visit	\$25 per visit
b. Specialist	\$25 per visit	\$40 per visit	\$25 per visit	\$40 per visit	\$25 per visit	\$40 per visit
Out-of-Network Deductible	\$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
Out-of-Network Reimbursement	<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
Inpatient/Outpatient Facility Copayment	\$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:

SUBJECT TO HOME OFFICE APPROVAL

Options	Tier 1	Tier 2	Tier 3	Mail-Order	Deductible ** (Please select one)
<input checked="" type="checkbox"/> Option 1	\$10 copayment	\$25 copayment	\$50 copayment	2x copayment	<input checked="" 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 Rx 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)

B. Freedom Plan Metro Access and Liberty Plan Metro Access (Non-gated - No referrals required)

Instructions: Please select a network; plan option and any additional benefit options as provided below.

Please Select Network:

Freedom® LibertySM

Plan #5

Options	<input type="checkbox"/> Metro Plan Access Option 1	<input checked="" type="checkbox"/> Metro Plan Access Option 2
Office visit copayment:	\$20 PCP/\$30 specialist	\$30 PCP/\$50 specialist
Hospital copayment	\$500 per admission per continuous confinement	\$500 per admission per continuous confinement
Outpatient/Hospital Ambulatory surgery	\$250 copayment	\$500 copayment
Out-of-Network deductible - Single/Family	\$2,000/\$6,000	\$3,000/\$9,000
Out-of-Network coinsurance - Single/Family	70% to \$10,000/\$30,000	70% to \$10,000/\$30,000
Out-of-Network reimbursement	<input type="checkbox"/> 150% of Medicare rate <input type="checkbox"/> 70% UCR	<input type="checkbox"/> 150% of Medicare rate <input checked="" type="checkbox"/> 70% UCR

Deductibles and out-of-pocket accumulators are on a calendar 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"/> \$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 checked="" 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 Rx 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 Plansm Metro (Non-gated - No referrals required)

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

#8

#4

Please Select Network:

Freedom[®]

Libertysm

Options	<input type="checkbox"/> Plan 1	<input type="checkbox"/> Plan 2 4 or 8	<input type="checkbox"/> Plan 3	<input type="checkbox"/> Plan 4	<input type="checkbox"/> Plan 5
Copayment: 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
Single Deductible	none	none	\$1,000	\$1,000	\$2,000
Family Deductible	none	none	\$2,000	\$2,000	\$4,000
Coinsurance	none	none	80% to \$10,000/\$20,000	90% to \$10,000/\$20,000	90% to \$10,000/\$20,000
Outpatient Facility Copayment	\$150 per incident	\$300 per incident	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Inpatient Facility Copayment	\$150 per continuous confinement	\$300 per day to five day maximum	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Emergency Room	\$75	\$75	\$75	\$75	\$75

Deductibles and out-of-pocket accumulation periods are on a calendar 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) #4 #8
<input checked="" type="checkbox"/> Option 1	\$10 copayment	\$25 copayment	\$50 copayment	2x copayment	<input checked="" type="checkbox"/> \$50 <input checked="" 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"/> 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 Rx 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)

D. Freedom Plan® DirectSM and Liberty Plan DirectSM

No referrals are required for these plan designs.

In-Network/Out-of-Network #3 #7
 Please Select Network: Freedom® LibertySM

Options	<input checked="" type="checkbox"/> Plan 1 3	<input type="checkbox"/> Plan 2	<input type="checkbox"/> Plan 3	<input type="checkbox"/> Plan 4	<input checked="" type="checkbox"/> Plan 5 7	<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
Copayment	\$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
Single Deductible	\$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
Family Deductible	\$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
Coinsurance	90%/70%	80%/60%	80%/60%	80%/60%	90%/70%	90%/70%	80%/60%	100%/70%	100%/70%	100%/70%
Out-of-Network	<input type="checkbox"/> 150% of Medicare rate / <input checked="" 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 checked="" 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
Single Maximum Out-of-Pocket	\$1,500/\$4,000	\$2,500/\$5,000	\$3,000/\$6,000	\$4,000/\$8,000	\$1,500/\$4,000	\$3,000/\$5,000	\$3,000/\$6,000	\$3,000/\$6,000	\$1,500/\$4,000	\$3,000/\$6,000
Family Maximum Out-of-Pocket	\$3,000/\$8,000	\$5,000/\$10,000	\$6,000/\$12,000	\$8,000/\$16,000	\$3,000/\$8,000	\$6,000/\$10,000	\$6,000/\$12,000	\$6,000/\$12,000	\$3,000/\$8,000	\$6,000/ \$12,000

Deductibles and out-of-pocket accumulation periods are on a calendar 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 checked="" type="checkbox"/> Option 1 #3	\$10 copayment	\$25 copayment	\$50 copayment	2x copayment	<input checked="" 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 checked="" type="checkbox"/> Option 3* #7	\$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 Rx 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 HSA Exclusivesm

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

Please Select Network: Freedom® Libertysm

No referrals are required for these plan designs.

In-Network Only

Options	Plan 1	Plan 2	Plan 3 #6
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 basis.

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

Options	Tier 1	Tier 2	Tier 3	Mail-Order
<input checked="" 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 copay 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 Rx 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

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.

Single	Couple	Parent/Children	Family
\$	\$	\$	\$

V. BROKER / AGENT INFORMATION

	Broker	Co-Broker	General Agent
1. Name of Broker/Agent :	NORMAN J. MICHAELS & ASSOCIATES		
2. Broker Code (Required):	BC0138		
3. Social Security # or Federal Tax ID #:	13-3165414		
4. Broker Street Address:	80 BUSINESS PARK DRIVE SUITE 306		
5. City, State, Zipcode:	ARMONK, NY 10504		
6. Telephone Number:	914-273-4723		
7. Fax Number:	914-273-4728		
8. E-mail Address:	dburgess@michaels-associates.com		
9. Commission Split %:	100%		
10. Sales Representative:	ANNAMARIA 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. 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.

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.

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.

X

Signature of Authorized Officer of the Company

Title

SIGN HERE

Witness

Duly Licensed Resident Agent/Broker



Plan Election

1 2 3 4
5 6 7 8

Please do not write in this area, for Oxford use only.

A UnitedHealthcare Company

New York Member Enrollment Form - OHI

Mailing Address: P.O. Box 7085, Bridgeport, CT 06601 • www.oxfordhealth.com

To Be Completed By EMPLOYER (Please Print)

NAME OF GROUP (EMPLOYER) GROUP NUMBER CONTRACT SPECIFIC PACKAGE (CSP) BILLING GROUP (BG)
EMPLOYEE'S EFFECTIVE DATE OF COVERAGE IS INDIVIDUAL COVERED UNDER COBRA? IF YES, QUALIFYING EVENT
DATE OF FULL-TIME EMPLOYMENT AVERAGE NO. OF HOURS WORKED PER WEEK EMPLOYEE OCCUPATION
EMPLOYER SIGNATURE DATE

To Be Completed By EMPLOYEE (Please Print)

SOCIAL SECURITY NO. LAST NAME
FIRST NAME MI BIRTH DATE HOME PHONE BUSINESS PHONE
STREET ADDRESS APT. NO. CITY STATE ZIP
WILL YOU HAVE ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD?
OXFORD CODE OF PRIMARY CARE PHYSICIAN SELECTED ARE YOU AN EXISTING PATIENT?
OXFORD CODE OF OB/GYN SELECTED (Female Members) ARE YOU AN EXISTING PATIENT?

EMPLOYEE'S Dependent Information Please only complete for dependents who will be covered on your Oxford policy (Please Print)

SPOUSE'S SOCIAL SECURITY NUMBER SPOUSE'S LAST NAME SPOUSE'S FIRST NAME MI
SPOUSE'S BIRTH DATE DATE OF MARRIAGE SPOUSE'S EMPLOYER
WILL YOU HAVE ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD?
OXFORD CODE OF PRIMARY CARE PHYSICIAN SELECTED ARE YOU AN EXISTING PATIENT? ID#
OXFORD CODE OF OB/GYN SELECTED (Female Members) ARE YOU AN EXISTING PATIENT?
ELIGIBLE CHILD'S SOCIAL SECURITY NO. ELIGIBLE CHILD'S LAST NAME ELIGIBLE CHILD'S FIRST NAME MI
ELIGIBLE CHILD'S BIRTH DATE IS THIS DEPENDENT DISABLED? WILL YOU HAVE ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD?
OXFORD CODE OF PRIMARY CARE PHYSICIAN SELECTED ARE YOU AN EXISTING PATIENT? ID#
OXFORD CODE OF OB/GYN SELECTED (Female Members) ARE YOU AN EXISTING PATIENT?
ELIGIBLE CHILD'S SOCIAL SECURITY NO. ELIGIBLE CHILD'S LAST NAME ELIGIBLE CHILD'S FIRST NAME MI
ELIGIBLE CHILD'S BIRTH DATE IS THIS DEPENDENT DISABLED? WILL YOU HAVE ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD?
OXFORD CODE OF PRIMARY CARE PHYSICIAN SELECTED ARE YOU AN EXISTING PATIENT? ID#
OXFORD CODE OF OB/GYN SELECTED (Female Members) ARE YOU AN EXISTING PATIENT?
ELIGIBLE CHILD'S SOCIAL SECURITY NO. ELIGIBLE CHILD'S LAST NAME ELIGIBLE CHILD'S FIRST NAME MI
ELIGIBLE CHILD'S BIRTH DATE IS THIS DEPENDENT DISABLED? WILL YOU HAVE ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD?
OXFORD CODE OF PRIMARY CARE PHYSICIAN SELECTED ARE YOU AN EXISTING PATIENT? ID#
OXFORD CODE OF OB/GYN SELECTED (Female Members) ARE YOU AN EXISTING PATIENT?

If you have additional dependents, please use another enrollment form to provide the necessary information. In order to help us quickly process this form and avoid delays, please make sure all areas are properly filled out.

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.

EMPLOYEE/APPLICANT SIGNATURE DATE SIGN HERE



Required Documentation for New York Groups of One and Sole Proprietor Business

We will accept applications from sole proprietors and S-Corporations with one eligible employee who is able to submit the following documentation and meet the standards outlined below:

Business Organizations in Operation More Than 12 Months

Instructions for Sole Proprietors:

- 1) Provide at least one of the following from most recent tax year:
 - Schedule C – Profit & Loss From Business (Sole Proprietorship)
 - Schedule C-EZ – Net Profit From Business (Sole Proprietorship)
 - Schedule F – Profit & Loss From Farming
- 2) Provide a current signed copy of first two pages of U.S. Individual Tax Return Form 1040
 - Any W-2 forms reported on the sole proprietor's 1040 must be submitted.
 - Gross income from Schedule C, C-EZ or F must exceed any W-2 income the applicant may have received.
- 3) Sign our Sole Proprietor and Group of One Attestation Form

Instructions for Corporations that have elected to be taxed as S-Corporations:

- 1) Provide an IRS Form 1120-S – Income Tax Form for S Corporations
- 2) Provide a Schedule K-1
 - Schedule K-1 must show 100% ownership (i.e. sole S-Corp shareholder) for prospective insured.
- 3) Provide a W-2
 - Received by the shareholder-employee from the S-Corporation under which group coverage with us is sought. In addition, if applicable, S-Corporation shareholder must provide any other W-2s reported on their 1040 from other business organizations.
 - Gross income from IRS Form 1120-S must exceed any W-2 income the applicant may have received from other business organizations.
- 4) Provide current signed copy of the first two pages of the U.S. Individual Tax Return Form 1040 and Schedule E (if applicable) for the S-Corporation shareholder who seeks coverage.

5) Sign the Oxford Sole Proprietor and Group of One Attestation Form

Business Organizations in Operation Less Than 12 Months

1) Provide the following:

- Certificate of Incorporation (for S-Corporations only)
- NYS Business License (if applicable)
- Copy of Business Bank Statement (for Sole Proprietors only)

2) Sign the Oxford Sole Proprietor and Group of One Attestation Form

Oxford reserves the right to modify the above eligibility requirements and required documentation.

A Third Party Administration Company

80 BUSINESS PARK DRIVE, SUITE 306
ARMONK, NEW YORK 10504

PHONE: 914-273-4723 FAX: 914-273-1376

*TriState Special
Marketing Corp.*

Direct Payment

TriState Special Marketing offers our clients the benefit of direct payment. Please fill out this form and attach a voided check, not a deposit slip. If paying from a savings account, ask your bank to give you the routing/transit number for your account and write it below.

If you are interested in taking advantage of direct payment please fill in the information below and mail it to:

TriState Special Marketing Corp.
80 Business Park Drive, Suite 306
Armonk, New York 10504
ATTN: Billing

Full Legal Name: _____ Social Security Number: _____

Email Address: _____ Date: _____

Direct Payment

The undersigned hereby requests and authorizes the entire amount of payment each period be withdrawn directly from the bank account named on the attached voided check. For savings account please write routing/transit number below.

Monthly Amount _____ Quarterly Amount _____
 Checking Account (voided check) Savings Account routing/transit # _____

Depository Name _____
Address _____
Routing Number _____ Account Number _____

Cancel Direct Payment.

The undersigned hereby cancels the authorization for direct deposit previously submitted.

Signature: _____ Date: _____

By signing this you authorize Tri State Special Marketing Corporation to initiate debit entries to the account indicated above for the purpose of payments of premiums and if necessary, credit entries and adjustments for any debit entries made in error. This authorization is to remain in full force and effect until TriState and bank indicated have received written notice from me of its termination in such time and in such manner as to afford Tri State and bank indicated reasonable opportunity to act on it.

PLEASE ATTACH VOIDED CHECK

*Please note that this authorization will remain in effect for the duration of the calendar year and that the amounts are subject to change upon renewal of the plan year. At such time a new authorization will be required for payments.