



Name of Company \_\_\_\_\_

6. Nature of business:

Grid for nature of business: 2 rows of 20 columns each.

7. SIC Code filed with the State of CT:

Grid for SIC Code: 4 columns.

8. Type of Organization:  Corporation  Partnership  Proprietorship  LLC  Other \_\_\_\_\_

9. Tax identification Code or Number: Federal I.D. \_\_\_\_\_

10. Did your group employ at least 1 but no more than 50 employees for at least 50% of your business days during the preceding 12 months?  Yes  No

III. ADMINISTRATIVE INFORMATION

The term "coverage" means the benefits provided by Oxford, pursuant to the Group Certificate.

1. Effective date: We request that this coverage be effective as of the first day of \_\_\_\_\_ (Month/Year).

2. Anniversary date: The anniversary date will fall annually on the first day of the calendar month of the approved effective date.

3. Other group health or individual coverage: Any other health coverage (including Medicare) while enrolled with Oxford should be indicated on the individual Member Enrollment Forms.

Please Note: Do not cancel existing coverage until you have received acceptance of this coverage by Underwriting.

If no previous coverage, initial here \_\_\_\_\_.

Table with 4 columns: Type of coverage, Name of carrier, Effective date, If terminated, date terminated. 3 rows.

4. Employer Contributions: Toward Employee Premium: \_\_\_\_\_ %

Toward Family Premium: \_\_\_\_\_ %

5. Eligibility and Termination: Each employee must be eligible on the date the insurance provided under the Certificate becomes effective with respect to him/her. If the employee is not eligible for coverage on the date the Certificate becomes effective, the employee must wait until he/she is eligible for coverage.

a) Employee Eligibility :

Full-Time Employees:  Please check here to confirm that all permanent full-time employees work a minimum 30 hours/week. Also, if the minimum hours are more than the required 30 hours, please enter the hours per week here \_\_\_\_\_.

Retired Employees:  Covered  Not Covered

b) Eligibility & Termination: The employee will become eligible on the latter of the effective date of this plan or the date selected below

Name of Company \_\_\_\_\_

Indicate number of months or days, whichever is applicable, in the space provided below. In (i) below, if there is no waiting period, insert "0" in the space provided for the number of days or months of continuous service. In (ii) below, 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.

**CLASS I**

**CLASS II**

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

**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.

**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.

**6. Number of Total Employees the Effective Date:**

Full-time employees \_\_\_\_\_ Part-time employees \_\_\_\_\_ Retired employees \_\_\_\_\_

Of the total employees: Were 51% or more active eligible full-time employees working in CT? \_\_\_\_\_

**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 will be coordinated with Medicare benefits for any employee over the age of 85 who is not actively at work.

**9. Dependent Eligibility:** Dependents are defined as follows:

- a legal spouse; and
- any child;
  - who has not reached age 19 or the limiting age; and
  - who is not married; and
  - who is chiefly dependent upon the employee for support.

The term "child" refers to the employee's children, including any legal stepchild, legally or proposed adoptive child who is physically placed in subscribers home, 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:

- no longer being a registered full-time student;
- reaching the age of:  23 (standard) or  25 (non-standard, additional cost) **(select one)**

If a child cannot support him/herself due to mental 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 Health Insurance 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.

**III. PRODUCT / PLAN DESIGN**

Please select one plan from either Section 1 or Section 2

**SECTION 1: Oxford USA - Plan Designs**

1. Please select a plan type and a plan number (if applicable):

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
Copayment	\$10	\$10	\$15	\$15	\$15	\$20
Single Deductible	\$250	\$500	\$300	\$1,000	\$500	\$1,000
Family Deductible	\$625	\$1,250	\$750	\$2,500	\$1,250	\$2,500
Coinsurance	80%	70%	80%	70%	70%	70%
Coinsurance Maximum	\$5,000	\$10,000	\$5,000	\$10,000	\$10,000	\$10,000

2. Please select a Prescription rider and desired coverages:

Pharmacy benefit: (Generic/ Preferred Brand/ Non-Preferred Brand copay)\*

- \$5/\$10/\$10
- \$5/\$15/\$15
- \$7/\$20/\$20
- \$5/\$10/\$25
- \$5/\$15/\$35
- \$7/\$15/\$35
- \$10/\$20/\$35
- None

\*All pharmacy benefits do not require a deductible.

Contraceptives:

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

3. Additional Benefit Information

- Vision
- None (Standard) Hospital copayment
- \$250 Hospital copayment
- \$500 Hospital copayment

Other: \_\_\_\_\_

\_\_\_\_\_  
SUBJECT TO HOME OFFICE APPROVAL

**Please Note:** Dental plans are not available for Oxford USA. Deductibles and Out-of-pocket Accumulation periods are on a calendar year basis.



Name of Company \_\_\_\_\_

**IV . BROKER / AGENT INFORMATION**

	<b>BROKER</b>	<b>GENERAL AGENT</b>
1. Full legal name of firm:	_____	_____
2. Address of firm:	_____	_____
3. Contact:	_____	_____
4. Telephone/Fax Number:	_____	_____
5. Social Security # or Fed. Tax ID #:	_____	_____
6. Broker and/or Agent ID Number:	_____	_____
7. Broker and/or Agent Commission %:	_____	_____
8. Account Executive: _____	Field Office: _____	Phone Number: _____

**V . CONSENT**

**AUTHORIZATION FOR BROKER TO ACT AS BENEFITS ADMINISTRATOR**

The undersigned hereby requests Oxford Health Insurance 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 Health Insurance 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 Oxford 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.

**VI . UNDERWRITING GUIDELINES**

*The undersigned authorized officer of the Applicant hereby confirms that the Applicant satisfies, and if this Application is accepted by Oxford, will continue to satisfy and remain in compliance with the Underwriting Guidelines set forth in Attachment A, hereto, and any additional underwriting guidelines that Oxford may promulgate and which Applicant is given notice of in conjunction with future renewals. The Applicant hereby acknowledges that if at any time it is not in compliance with such underwriting guidelines or if any census data provided by the Applicant to Oxford, in conjunction with this Application for coverage do not accurately reflect, in the judgment of Oxford, the actual Applicant members 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 Applicant, to increase the monthly premiums payable by the Applicant 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

\_\_\_\_\_  
Signature of Authorized Officer of Company

\_\_\_\_\_  
Title of Officer of Company

\_\_\_\_\_  
Date

Name of Company \_\_\_\_\_

## VII. 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 acknowledges that the Effective Date of Coverage is not guaranteed and is subject to receipt by Oxford of full requirements including completed Family Health Statements for all employees and their dependents enrolling for coverage. 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.

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

X

\_\_\_\_\_  
Signature of Authorized Officer of the Applicant

\_\_\_\_\_  
Title of Officer of Applicant

\_\_\_\_\_  
Date

X

\_\_\_\_\_  
Duly Licensed and Appointed Producer\*

\_\_\_\_\_  
Date

**\*Please note: If you are not currently appointed by Oxford in CT, you must contact Oxford's Commissions Department at 888-666-6844 in advance of executing this application.**



Oxford Health Plans<sup>®</sup>  
**there is another way<sup>®</sup>**