

14. 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

II. SPECIFICATIONS FOR COVERAGE

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

SECTION 1: FREEDOM PLAN & LIBERTY PLAN

HEALTH BENEFITS

- Plan: C D E HMO
 Product: PPO (C) PPO (C or D) - Liberty Network only POS (C,D, or E)
 Network: Freedom Liberty
 Copayment (Plans C,D,E,HMO): \$5 \$10 \$15 \$20 \$15/\$25 \$30
 Deductible (C,D,E) \$200 \$250 \$500 \$750 Rider \$1,000 \$2,000 \$2,500

OPTIONS FOR PLANS D AND E ONLY:

- Physician Visits for Preventive Care at No Charge
 Hospital Confinement at No Charge
 Coinsured Charge Limit: \$5,000 Rider \$8,333 Rider \$10,000 Standard
 Physical Therapy 90 Rider
 Vision Care Rider
 Enhanced Dental Rider
 Premium Dental Rider

PRESCRIPTION DRUG BENEFITS

Copayment Information:

- Standard (Plan Copay)
Optional Riders (Generic/Preferred Brand/Brand Copay)
 \$5/\$15/\$50* \$7/\$20/\$50* \$7/\$15/\$25 \$7/\$15/\$35* \$10/\$25/\$50* \$15/50%
 *Pharmacy Deductible (Waived for generic drugs): None \$50
 Oral Contraceptives: Yes No (Qualified State Exempt Groups Only)

SECTION 2: FREEDOM PLAN DIRECT & LIBERTY PLAN DIRECT

HEALTH BENEFITS:

- Freedom Plan Direct Liberty Plan Direct

In-Network/Out-of-Network

Options	<input type="checkbox"/> Plan B	<input type="checkbox"/> Plan C
PCP/Specialist Copayment	N/A	<input type="checkbox"/> None <input type="checkbox"/> \$15/\$25 <input type="checkbox"/> \$30/\$30
Single Deductible	<input type="checkbox"/> \$1,000/\$1,000 <input type="checkbox"/> \$2,500/\$2,500	<input type="checkbox"/> \$500/\$500 <input type="checkbox"/> \$1,000/\$1,000 <input type="checkbox"/> \$2,000/\$2,000
Family Deductible	<input type="checkbox"/> \$2,000/\$2,000 <input type="checkbox"/> \$5,000/\$5,000	<input type="checkbox"/> \$1,000/\$1,000 <input type="checkbox"/> \$2,000/\$2,000 <input type="checkbox"/> \$4,000/\$4,000
Coinsurance	80%/60%	90%/70%
Single Coinsurance Maximum Charge Limit	\$10,000	\$10,000

II. SPECIFICATIONS FOR COVERAGE (CONT'D)

DIRECT OPTIONS:

- Vision Care Rider
- Enhanced Dental Rider
- Premium Dental Rider

PRESCRIPTION DRUG BENEFITS

Copayment Information:

- Standard (Plan Copay) Available only with office visit copay plans

Optional Riders (Generic/Preferred Brand/Brand Copay)

- \$7/\$15/\$25 \$10/\$25/\$50* \$15/50%*

*Pharmacy Deductible (Waived for generic drugs): None \$50

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

SECTION 2: 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

Options	<input type="checkbox"/> Plan 1	<input type="checkbox"/> Plan 2	<input type="checkbox"/> Plan3
Copayment	\$30	N/A	N/A
Single Deductible (In-network/Out-of-network)	\$1,000/\$1,000	\$2,000/\$2,000	\$1,000/\$1,000
Family Deductible (In-network/Out-of-network)	\$2,000/\$2,000	\$4,000/\$4,000	\$2,000/\$2,000
Coinsurance (In-network/Out-of-network)	90%/70%	90%/70%	80%/60%
Single Coinsurance Maximum Charge Limit	\$10,000	\$10,000	\$10,000

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

- Vision

PRESCRIPTION DRUG BENEFITS:

Prescription Drug Plan: Yes No

Copayment Information:

- Standard (Plan Copay) Available only with Plan #1.

Optional Riders Generic/Preferred Brand/Brand Copay)

- \$7/\$15/\$25 \$10/\$25/\$50* \$15/50%*

*Pharmacy Deductible (waived for generic drugs): None \$50

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

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
 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.

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 retirees 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 Health Insurance, Inc. to make or modify any request or application for insurance or to bind Oxford Health Insurance, Inc. 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 Health Insurance, Inc. 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