UnitedHealthcare®
Oxford

Freedom Plan® Classic℠
Freedom Plan® Access℠
Freedom Plan® Direct℠
Freedom Plan® Value Option℠
Oxford MyPlan℠
Oxford® HSA Direct℠
Oxford USA℠

Connecticut Large Group Application-OHI

Oxford Health Insurance, Inc.

Mailing Address: 4 Research Drive, Shelton, CT 06484 ▪ www.oxfordhealth.com

I. GENERAL INFORMATION

1. **Full Legal Name of Firm:**

2. **Address of firm:**
   (Street Address
   City, State, Zip Code
   Do not use a P.O. Box.)

3. **Plan Administrator/Contact:**
   a. Name and Title:
   b. Address:
   (If different from address of firm)
   (Street Address
   City, State, Zip Code
   Do not use a P.O. Box.)
   c. Phone Number: Area Code
   d. Fax Number: Area Code
   e. Email Address:

4. **Name and title of person to receive correspondence/billing statements (if different from above):**
   a. Name:
   b. Title:
   c. Address:
   (Street Address
   City, State, Zip Code)
   d. Phone Number: Area Code
   e. Fax Number: Area Code

5. **Start Date of Business:**

6. **Full Legal Name & Address of Parent Company:**
   a. Name:
   b. Address:
   (Street Address
   City, State, Zip Code)

7. **Full Legal Name & Address of Each Subsidiary and/or Affiliated Company, Branch or Satellite Office whose Employees are to be Covered:**
   a. Name:
   b. Address:
   (Street Address
   City, State, Zip Code)

8. **Nature of Business:**

9. **SIC Code:** _____

10. **Type of Organization:** ❒ Corporation ❒ Partnership ❒ LLC ❒ LLP ❒ Other _____
Did you have any employees other than yourself and your spouse during the preceding calendar year? ❒ Yes ❒ No

11. **Tax Identification Code or Number:**

a. Federal I.D. _____

12. **Enter the Prior Calendar Year Average Total Number of Employees** _____
Under the Health Care Reform law, the number of employees means the average number of employees employed by the company during the preceding calendar year. An employee is typically any person for which the company issues a W-2, regardless of full-time, part-time or seasonal status or whether or not they have medical coverage.

To calculate the annual average, add all the monthly employee totals together, then divide by the number of months you were in business last year (usually 12 months). When calculating the average, consider all months of the previous calendar year regardless of whether you had coverage with us, had coverage with a previous carrier or were in business but did not offer coverage. Use the number of employees at the end of the month as the "monthly value" to calculate the year average. If you are a newly formed business, calculate your prior year average using only those months that you were in business. Use whole numbers only (no decimals, fractions or ranges).

13. **Enter the Prior Calendar Year Full Time Equivalent Total Number of Employees** _____

For purposes of determining your number of full-time equivalent employee count, the number of employees means the average number of employees employed full-time (at least 30 hours/week in any given month), by the company on business days during the preceding calendar year. In addition to the number of full-time employees noted above, for any month otherwise determined, include for such month the number of full-time employees divided by the aggregate number of hours of service of all employees who are not full-time employees for the month by 120. Employers should exclude employees who were seasonal workers who worked 120 days or fewer in the preceding calendar year.

14. **Subject to ERISA?** ❒ Yes ❒ No (Most private sector plans are ERISA plans)
If No, please indicate appropriate category:
❒ Church (Additional information needed)
❒ Indian Tribe – Commercial Business
❒ Foreign Government/Foreign Embassy
❒ Federal Government
❒ Non-Federal Government (State, Local or Tribal Gov.)
❒ Non-ERISA Other _____

15. **Does your group sponsor a plan that covers employees of more than one employer?** ❒ Yes ❒ No
If you answered Yes, then indicate which of the following most closely describes your plan:
❒ Professional Employer Organization (PEO)
❒ Multiple Employer Welfare Arrangement (MEWA)
❒ Taft Hartley Union
❒ Governmental
❒ Church
❒ Employer Association

16. **Is your group a Professional Employer Organization (PEO) or Employee Leasing Company (ELC), or other such entity that is a co-employer with your client(s) or client-site employee(s)?** ❑ Yes ❑ No

17. **Do you currently utilize the services of a Professional Employer Organization (PEO) or Employee Leasing Company (ELC), Staff Leasing Company, HR Outsourcing Organization (HRO), or Administrative Services Organization (ASO)?**
❑ Yes ❑ No

18. **Do you have common ownership with any other businesses?** ❑ Yes ❑ No
If you own multiple companies, or a parent-subsidiary relationship exists between your company and another, this may indicate common ownership of businesses.

19. **Do you continue medical coverage during a leave of absence (not including state continuation or COBRA coverage), and if so, for how long once an employee begins a leave of absence?** (Please refer to the applicable state and federal rules that may require benefits to be provided for a specific length of time while an employee is on leave.)
    - ❒ Last Day worked (following the last day worked for the minimum hours required to be eligible)
    - ❒ 3 Months (following the last day worked for the minimum hours required to be eligible)
    - ❒ 6 Months (following the last day worked for the minimum hours required to be eligible)
    - ❒ No, we do not offer medical coverage during a leave of absence

    If the employer continues to pay required medical premiums and continues participating under the medical policy, the covered person's coverage will remain in force for:
    (1) No longer than 3 consecutive months if the employee is: temporarily laid-off; in part time status; or on an employer approved leave of absence.
    (2) No longer than 6 consecutive months if the employee is totally disabled.
    If this coverage terminates, the employee may exercise the rights under any applicable Continuation of Medical Coverage provision or the Conversion of Medical Benefits provision described in the Certificate of Coverage.
    The Employer's decision to refuse to offer coverage cannot be based upon health status related factors.

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 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:** Indicate below other coverage that is still in force or that has terminated within the past three (3) years.

Type of coverage	Name of carrier	Effective date	If terminated, date terminated

4. **Employer Contributions:** Toward employee premium: _____% Toward family premium: _____%
   Please note: **Employer contribution must be at least 50% toward employee premium.**
5. **Eligibility and Termination:** Each employee must be eligible on the date the insurance provided under the Certificate of Coverage becomes effective with respect to him/her. If the employee is not eligible for coverage on the date the Certificate of Coverage 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 _____.

   Are any classes excluded? ❒ Yes ❒ No
   If yes, indicate classes excluded: _____

   Part-Time Employees: ❒ Yes, part-time employees who work at least ___ hours per week (minimum of 20 hours/week)
   ❒ Not covered

   Retired Employees: ❒ Covered ❒ Not covered

   The definition of a retired employee is:
   - ❒ an employee who is retired on pension by the employer
   - ❒ an employee who is retired on pension by the employer and who immediately prior to the date of retirement had completed at least ____ years of service with the employer
   - ❒ an employee who is retired from service by the employer and who immediately prior to the date of retirement had completed at least ____ years of service with the employer

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

Indicate number of months or days, whichever is applicable, in the space provided below. [Waiting period cannot exceed 90 days.] 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 the first day of the calendar month coinciding with or following the date that the employee completes the group specified length of continuous service.

CLASS I

Definition of Class I _____

_____

i) Eligibility

❑ Date that the employee completes:

*_____ month(s) of continuous service, or

*_____ days of continuous service

Termination

❑ Date of termination of employment

ii) Eligibility

❑ On the first day of the calendar month coinciding with or following the date that the employee completes:

*_____ month(s) of continuous service, or

*_____ days of continuous service

Termination

❑ On the last day of the calendar month in which the employee's employment terminates.

iii) Waiting Period for Rehires

Waiting period waived for rehires? ❒ Yes ❒ No
If yes, waived if rehired within _____months.

iv) Waiting Period for Full-Time Employees

Waiting period waived for existing full-time employees?
❒ Yes ❒ No

CLASS II

Definition of Class II _____

_____

i) Eligibility

❑ Date that the employee completes:

*_____ month(s) of continuous service, or

*_____ days of continuous service

Termination

❑ Date of termination of employment

ii) Eligibility

❑ On the first day of the calendar month coinciding with or following the date that the employee completes:

*_____ month(s) of continuous service, or

*_____ days of continuous service

Termination

❑ On the last day of the calendar month in which the employee's employment terminates.

iii) Waiting Period for Rehires

Waiting period waived for rehires? ❒ Yes ❒ No
If yes, waived if rehired within _____months.

iv) Waiting Period for Full-Time Employees

Waiting period waived for existing full-time employees?
❒ Yes ❒ No

6. **Number of Employees Eligible on Effective Date:** Full-Time Employees ____ Part-Time Employees ____ Retired Employees ____

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 integrated with Medicare Benefits for retired employees age 65 or over and their dependents age 65 or over if the group offers retiree coverage.

9. **Dependent Eligibility:** Dependents are defined as follows:
   - a legal spouse
   - any child (natural, adopted, placed for adoption, or step child) of the insured or insured's spouse who is under the age of 26

   Coverage for dependent children who have reached the limiting age ends on the group's policy anniversary date following the attainment of the limiting age.

   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 provided proof of such incapacity and dependency is furnished to Oxford 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.

10. **Plan Exclusions and Limitations:** Please refer to your Group Certificate of Coverage for a complete list of exclusions and limitations.

III. PRODUCT/PLAN DESIGN

Please select from Sections 1, 2, 3, 4, or 5 for in-area employees.
Please select from Section 6 (Oxford USA) for out-of-area employees.

SECTION 1: Freedom Plan Classic (Gated) and Freedom Plan Access (Non-Gated)

1. **Conversion Status:** ❑ Full Conversion ❑ Offering

2. **Product:** ❑ Freedom Plan Classic ❑ Freedom Plan Access

Note: If more than one product/plan design has been selected, please attach a photocopy of this selection to your application.

3. **Please complete section below:**

Office Copayment _____
Deductible _____
Family Multiple _____
Coinsurane _____
Coinsurance Maximum (%) _____

4. **Please select optional prescription drug coverage:**

Prescription Plan: ❑ Yes ❑ No
Copayment Tier 1 Drugs _____
Copayment Tier 2 Drugs _____
Copayment Tier 3 Drugs _____
Prescription Deductible _____
Contraceptives ❑ Yes (Standard) ❑ No (Qualified State Exempt Groups Only)

Out-of-network Reimbursement:
_____ UCR Fee schedule [1]
_____ Medicare rate [2]

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

5. **Additional Benefit Information (All information is subject to Home Office approval):**

Vision: ❑ $50 exam/$70 appliances ❑ $50 exam/$200 appliances
❑ Domestic Partner (100+ life groups)
❑ Unlimited Home Healthcare ❑ Unlimited Skilled Nursing Facility
Physical Therapy: ❑ Outpatient (90 visits per condition) ❑ Long-Term (100 visits per year)
Dental: ❑ Premium ❑ Enhanced
Emergency Room Copayment: ❑ $50 ❑ $75 (Standard) ❑ $100 ❑ $150

Hospital Copayment (Inpatient/Outpatient): ❑ No Copayment
❑ $100/$50 per admit
❑ $250/$100 (Standard) per admit
❑ $500/$250 per admit
❑ $500 per day to $2,000 annual maximum/$250 per admit
❑ $500 per day to $2,000 annual maximum/$100 per admit
❑ $500 per day to $2,000 annual maximum/$0 per admit

Other (please specify) :_____

_____

_____

_____

_____

_____

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III. PRODUCT/PLAN DESIGN (continued)

SECTION 2: Freedom Plan Direct

1. **Please check the box corresponding to the product selected:**
   Note: If more than one product/plan design has been selected, please attach a photocopy of this selection to your application specifying the additional information.

   ❑ **Freedom Plan Direct (Office Visit Copayment)** ❑ **Freedom Plan Direct (Deductible & Coinsurance Only)**

   Please note: No referrals are required for these plan designs.

2. **Please complete section below (if applicable):**
   Office Visit Copayment: _____

   In-network
   Deductible: _____
   Coinsurance: _____
   Coinsurance Maximum: _____

   Out-of-network
   Deductible: _____
   Coinsurance: _____
   Coinsurance Maximum: _____
   Out-of-network Reimbursement:
   _____ UCR Fee schedule [1]
   _____ Medicare rate [2]

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

3. **Please select a prescription rider and desired coverages:**
   Prescription Plan: ❑ Yes ❑ No

   Copayment Tier 1 Drugs _____
   Copayment Tier 2 Drugs _____
   Copayment Tier 3 Drugs _____
   Prescription Deductible _____
   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

4. **Additional Benefit Information (All information is subject to Home Office approval):**

   Vision: ❑ $50 exam/$70 appliances ❑ $50 exam/$200 appliances

   ❑ Unlimited Skilled Nursing Facility ❑ Unlimited Home Healthcare

   ❑ Domestic Partners (100+ life groups)

   Emergency Room Copayment: (for office visit copayment plans only) ❑ $75 ❑ $100 ❑ $150

   Physical Therapy: ❑ Outpatient (90 visits per condition/lifetime) ❑ Long-Term (100 visits per calendar year)

   Dental: ❑ Premium ❑ Enhanced

   ❑ Other (please specify): _____

   _____

   _____

   _____

   _____

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III. PRODUCT/PLAN DESIGN (CONTINUED)

SECTION 3: Freedom Plan Value Option

1. Please complete section below (if applicable):

❑ Office Visit Copayment: _____

In-network
Deductible: _____

Out-of-network
Deductible: _____
Coinsurance: _____
Coinsurance Maximum: _____

Out-of-network Reimbursement:
_____ UCR Fee schedule [1]
_____ Medicare rate [2]

2. Please select a prescription rider and desired coverages:

Prescription Plan: ❑ Yes ❑ No
If yes, copayment information:
Tier 1: _____
Tier 2: _____
Tier 3: _____
Prescription Deductible (if applicable): _____
Mail-Order

❑ 1x retail copayment for 90-day supply ❑ 2x retail copayment for 90-day supply
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
Deductible Options: (Deductibles are waived for Tier 1 drugs)

❑ None ❑ $50 ❑ $100* ❑ $150*
(*Available with 1x retail copayment mail-order only)

Contraceptives: ❑ Yes (Standard) ❑ No (Qualified State Exempt Groups Only)

3. Additional Benefit Information:

Vision:	❑ $50 exam/$70 appliances	❑ $50 exam/$200 appliances		
Emergency Room Copayment:	❑ $50	❑ $75 (Standard)	❑ $100	❑ $150
Skilled Nursing Facility:	❑ 30 Visits (Standard)	❑ Unlimited		
Outpatient Physical Therapy:	❑ 60 Visits (Standard)	❑ 90 Visits		

Note: Dental plans are not available for Freedom Plan Value Option plans.

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

III. PRODUCT/PLAN DESIGN (CONTINUED)

SECTION 4: Oxford MyPlan

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

1. Please check the box corresponding to the product selected:
Note: If more than one product/plan design has been selected, please attach a photocopy of this selection to your application specifying the additional information.

❑ **Oxford MyPlan (Office Visit Copayment)** ❑ **Oxford MyPlan (Deductible & Coinsurance Only)**

Please note: No referrals are required for these plan designs.

2. Please complete section below (if applicable):

❑ Office Visit Copayment: _____ ❑ None (Deductible & Coinsurance Only)

In-network
Deductible: _____
Coinsurance: _____
Coinsurance Maximum: _____

Out-of-network
Deductible: _____
Coinsurance: _____
Coinsurance Maximum: _____

Out-of-network Reimbursement:
_____ UCR Fee schedule [1]
_____ Medicare rate [2]

Please note: Family deductible and out-of-pocket expenses are two times the single amount.
Deductibles and out-of-pocket accumulation periods are on a ❑ calendar year basis ❑ contract year basis.

3. Please select a prescription rider and desired coverages:

Prescription Plan: ❑ Yes ❑ No

Contraceptives: ❑ Yes (Standard) ❑ No (Qualified State Exempt Groups Only)

If yes, copayment information:
Tier 1: _____ Tier 2: _____
Tier 3: _____ Prescription Deductible (if applicable): _____

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

4. Additional Benefit Information (All information is subject to Home Office approval):

Vision: ❑ $50 exam/$70 appliances ❑ $50 exam/$200 appliances

Dental: ❑ Premium ❑ Enhanced

III. PRODUCT/PLAN DESIGN (CONTINUED)

SECTION 5: Oxford HSA Direct

Please note: **No referrals are required for these plan designs. Groups enrolling in the Oxford HSA Direct must also fill out an Oxford HSA Employer Notification Form (#7423).**

1. Please complete section below (if applicable): *

In-network

Deductible:* _____

Copayment: _____

Coinsurance: _____

Coinsurance Maximum: _____

Out-of-network

Deductible: _____

Coinsurance: _____

Coinsurance Maximum: _____

Out-of-network Reimbursement:
_____ UCR Fee schedule [1]
_____ Medicare rate [2]

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

Prescription Plan (Required) *

Copayment Tier 1 Drugs _____
Copayment Tier 2 Drugs _____
Copayment 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

***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.

2. Additional Benefit Information (All information is subject to Home Office approval):

Vision: ❑ $50 exam/$70 appliances ❑ $50 exam/$200 appliances

❑ Unlimited Skilled Nursing Facility ❑ Unlimited Home Healthcare

❑ Domestic Partners (100+ life groups)

Physical Therapy: ❑ Outpatient (90 visits per condition/lifetime) ❑ Long-Term (100 visits per calendar year)

Dental: ❑ Premium ❑ Enhanced

❑ Other (please specify): _____

_____

III. PRODUCT/PLAN DESIGN (CONTINUED)

SECTION 6: Oxford USA **Please select an Oxford USA plan from either Section A or B for out-of-area employees.**

A) ❑ Oxford USA (non-gated POS options)

1. Please complete section below:

Office Visit Copayment: _____
Deductible: _____
Coinsurance (%): _____
Coinsurance Maximum: _____
Family Multiple (2,2.5,3): _____

Out-of-network Reimbursement:
_____ UCR Fee schedule [1]
_____ Medicare rate [2]

Note: If more than one product/plan design has been selected, please attach a photocopy of this selection to your application.

2. Please select optional prescription drug coverage:

Prescription Plan: ❑ Yes ❑ No

If yes, copayment information:

Tier 1:_____
Tier 2:_____
Tier 3: _____
Prescription Deductible (if applicable): _____

Mail-Order

❑ 1x retail copayment for 90-day supply ❑ 2x retail copayment for 90-day supply

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

3. Additional Benefit Information:

Domestic Partner:	❑ (100+ life group)	❑ Hospice		
Vision:	❑ $50 exam/$70 appliances	❑ $50 exam/$200 appliances		
Inpatient Hospital Room Copayment:	❑ $0 (Standard) ❑ $250 per admit	❑ $100 per admit ❑ $500 per admit		
Inpatient/Outpatient Hospital Room Copayment:	❑ $100/$50 per admit ❑ $500/$250 per admit	❑ $250/$100 per admit		
Outpatient Physical Therapy:	❑ 60 Visits (Standard) ❑ Enhanced Chiropractic	❑ 90 Visits	❑ Prosthetics	
Emergency Room Copayment:	❑ $50	❑ $75 (Standard)	❑ $100	❑ $150
Skilled Nursing Facility:	❑ 30 Visits (Standard)	❑ Unlimited		

III. PRODUCT/PLAN DESIGN (CONTINUED)

B) Oxford USA (Based on in-area Freedom Plan Direct)

1. ❑ **Oxford USA (Office Visit Copayment)** ❑ **Oxford USA (Deductible & Coinsurance Only)**
❑ **Oxford USA HSA (Based on in area HSA Direct)**

Please note: No referrals are required for these plan designs.

2. **Please complete section below (if applicable):**
Office Visit Copayment: _____

In-network	**Out-of-network**
Deductible**: _____	Deductible: _____
Coinsurance: _____	Coinsurance: _____
Coinsurance Maximum: _____	Coinsurance Maximum: _____

Out-of-network Reimbursement:
_____ UCR Fee schedule [1]
_____ Medicare rate [2]

Please note: Family deductible and out-of-pocket expenses are two times the single amount.

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

3. **Please select a prescription rider and desired coverages: (Required for HSA)****

Prescription Plan: ❑ Yes ❑ No

If yes, copayment information:
Tier 1: _____
Tier 2: _____
Tier 3: _____
Prescription Deductible (if applicable): _____

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

****NOTE: If selecting an Oxford USA HSA -**
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. Out-of-network benefits are accumulated separately.

4. **Additional Benefit Information (All information is subject to Home Office approval):**

Vision: ❑ $50 exam/$70 appliances ❑ $50 exam/$200 appliances

❑ Unlimited Home Healthcare

❑ Unlimited Skilled Nursing Facility

❑ Domestic Partners (100+ life groups)

Physical Therapy: ❑ Outpatient (90 visits per condition) ❑ Long-Term (100 visits per year)

Emergency Room Copayment: (for office visit copayment plans only) ❑ $75 ❑ $100 ❑ $150

❑ Other (please specify): _____

SUBJECT TO HOME OFFICE APPROVAL

IV. 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 the Applicant is given notice of in conjunction with future renewals. The Applicant hereby acknowledges that if at any time he/she 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 does 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

V. COBRA AND 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? _____

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 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).

_____

NAME OF BROKER OR GENERAL AGENT

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. BROKER/AGENT AGREEMENT

	Broker	Co-Broker	General Agent
1. Name of Payee:			
2. Payee's Oxford Broker Code (Required):			
3. Payee's Social Security # or Federal Tax ID #:			
4. Name of Writing Agent (Required if Payee is a company):			
5. Writing Agent's Oxford Broker Code (Required if Payee is a company):			
6. Commission Split %:			
7. Sales Representative:			
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. In general, our total bonuses are less than 10% of total producer compensation paid. 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.

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 he/she will not cancel any current health coverage he/she 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 health insurance policy terminated within the past 12 months due to failure to pay premiums.

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:_____ this _____ day of _____ 20_____

Applicant Name (Correct Legal Name)

X _____

Signature of Authorized Officer of the Applicant | **Title of Officer of Applicant**

X _____ X _____

Witness | **Duly Licensed Resident Agent/Broker**

***Please note: If you are not currently appointed by Oxford in CT, you must contact the Commissions Department at 1-888-666-6844 in advance of executing this application.**

[1] The Standard and High UCR fee schedules contain the maximum allowable fees and are set using data from Ingenix, Inc., the Centers for Medicare and Medicaid Services (CMS) and sources recognized by the federal government and insurance industry as a basis for evaluating and establishing fees. Physician fees are generally set using data from the Prevailing Healthcare Charges System (PHCS) database maintained by Ingenix. We use 70th percentile PHCS data for the standard UCR fee schedule and 80th percentile PHCS data for the high UCR fee schedule. We and Ingenix are related companies through common ownership by UnitedHealth Group. The fee schedule for physician-administered pharmaceutical products is based upon a percentage of Average Wholesale Price. If a data source is no longer available, we will use a comparable data source to establish fees.

[2] When a Medicare rate is not available, reimbursement is based upon certain gap methodology, including a gap methodology using relative value data from Ingenix, Inc. We and Ingenix are related companies through common ownership by UnitedHealth Group. When a gap methodology is not available, reimbursement is based upon 50% of the provider's billed charge.