UnitedHealthcare®
Oxford

Freedom Plan®
Freedom Plan® Select℠
HMO
HMO HSA
HMO Select
Primary Advantage

Connecticut Large Group Application - OHP

Oxford Health Plans (CT), 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 *Please - Do not use a PO Box.)

3. **Plan Administrator/Contact:**
   a. Name and Title:
   b. Address:
   (If different from address of company)
   c. Phone Number: Area Code
   d. Fax Number: Area Code
   e. Email address:

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

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:

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. _____

b. State Tax 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.

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 which is still in force or that which 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: _____%

*** Employer contribution must be at least 50% towards Employee 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: All permanent full-time employees who work at least ___ hours per week (minimum 30 hours/week).
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 & 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. In (i) below, if there is no waiting period, insert "O" 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. Waiting period cannot exceed 90 days.

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**

v) Dependent Cut-Off

❒ End of Semester
❒ End of Calendar Year
❒ Other (requires Home Office approval)

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**

v) Dependent Cut-Off

❒ End of Semester
❒ End of Calendar Year
❒ Other (requires Home Office approval)

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. Health Benefits covered by Medicare Part A, Part B and Part D are carved out 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 for a complete list of exclusions and limitations.

III. PRODUCT/PLAN DESIGN

1. Please check the box corresponding to the product selected:

❑ HMO
❑ HMO HSA
❑ HMO Plan Select
❑ Freedom Plan
❑ Freedom Plan Select
❑ Primary Advantage
❑ Other:_____
(subject to Home Office approval)

2. Please check the box corresponding to the network selected:

❑ Freedom
❑ Other:_____
(subject to Home Office approval)

3. Please complete section below:

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

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

Out-of-network Reimbursement:

_____ UCR Fee schedule[1]
_____ Medicare rate[2]

Note: Out-of-network reimbursement field does not apply to HMO products.

4. Additional Benefit Information:

Prescription Plan : ❑ Yes ❑ No
Contraceptives: ❑ Yes (Standard) ❑ No (Qualified State exempt groups only)
Mail order: ❑ 1x Retail copayment/90 day supply ❑ 2x Retail copayment/90 day supply

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

Vision:
❑ $50 exam/$70 appliances
❑ $50 exam/$200 appliances
❑ Prosthetics
❑ Dental Plan Premium
❑ Hospital Room Copay _____ PLEASE SPECIFY
❑ Enhanced Chiropractic
❑ Dental Plan Enhanced
❑ Emergency Room Copay _____ PLEASE SPECIFY
❑ 90 Visit Physical Therapy
❑ Skilled Nursing Facility
❑ Alternative Medicine _____ PLEASE SPECIFY

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 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

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. BROKER/AGENT INFORMATION

	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.

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 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 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

Witness

X

Duly Licensed Resident Agent/Broker

***Please note: If you are not currently appointed by Oxford in CT, you must contact the Commissions Department at 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.