New Jersey Large Employer Application - OHP

Oxford Health Plans (NJ), 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)

3. **Plan Administrator/Contact:**

   a. Name and Title:

   b. Address:

   (If it differs from address of firm; cannot be a P.O. Box)

   c. Phone Number:

   Area Code

4. **Plan year-end date:**

5. **Name and title of person to receive correspondence/billing statements:**
   (for purpose of maintaining plan's fiscal records)

   a. Name:

   b. Title:

   c. Address:

   (Street Address
   City, State, Zip Code)

   d. Phone Number:

   Area Code

6. **Full legal name of each subsidiary and/or affiliated company whose employees are to be covered:**

7. **Nature of business:**

8. **SIC Code:**

9. **Type of Organization:** ❒ Corporation ❒ Partnership ❒ LLC ❒ LLP ❒ Other _____

10. Enter the Prior Calendar Year Average Total Number of Employees _____

Under 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).

11. 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.

12. 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 _____

13. 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

14. 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

If you answered Yes, then by signing this application you agree with the certification in this section.

I hereby certify that my company is a PEO, ELC or other such entity and that only those employees that are the corporate employees of my company, and not my co-employees, are permitted to enroll in this group policy. If my group at any point after I sign this application determines that the group will provide coverage to the co-employees under the group's plan, I understand that Oxford Health Plans, Inc. will not cover the co-employees under this group policy.

15. 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

16. 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.

17. UnitedHealthcare's Leave of Absence (LOA) Policy; Eligibility for Medical Coverage

If the employee is on an employer approved leave of absence and the employer continues to pay required medical premiums, the coverage will remain in force for: (1) No longer than 13 consecutive weeks for non-medical leaves (i.e. temporarily laid-off). (2) No longer than 26 consecutive weeks for a medical leave. Coverage may be extended for a longer period of time, if required by local, state or federal rules.

If the employee's medical coverage terminates under this LOA policy, 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.

Do you continue medical coverage during a leave of absence (not including state continuation or COBRA coverage)?

___ Yes, we continue medical coverage during an approved leave of absence for full time* employees (as defined in section II).

___ No, we do not offer medical coverage during a leave of absence.

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 and Policy.

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

2. **Anniversary date:** The anniversary date is the first day of the calendar month which is shown in the effective date.

3. **Other group health or HMO coverage:** Indicate below other group health coverage which is still in force or which terminated within the past three (3) years.

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

4. **Contribution basis:** **Employer contribution percentage**

Employee: Health _____%

Family: Health _____%

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 on the date the Certificate becomes effective, the employee must wait until the next day on which he/she is eligible to begin coverage.

a) Employee Eligibility:

Active 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:_____

_____

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 (check appropriate date).

CLASS I

Definition of Class I _____

_____

i) Eligibility

❑ Date on which the employee completes:

*_____ months 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 next following the date on which the employee completes:

*_____ months of continuous service, or

*_____ days of continuous service.

Termination

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

CLASS II

Definition of Class II _____

_____

i) Eligibility

❑ Date on which the employee completes:

*_____ months 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 next following the date on which the employee completes:

*_____ months of continuous service, or

*_____ days of continuous service.

Termination

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

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

6. **Number of Employees Eligible on Effective Date:** Active 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 (includes Civil Union Partners);
   - any child who has not reached age 26; and
   - a Domestic Partner (at the option of the Group).

   The term "child" means the employee's children, including any legal stepchild, adopted child, or child for whom the employee or employee's spouse is the court appointed legal guardian.

   If a child cannot support him/herself due to intellectual disability 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 Plans 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:** Common exclusions and plan provisions are attached to this Application. Please refer to your Group Certificate and Policy for a complete list of exclusions and limitations.

III. PRODUCT/PLAN DESIGN

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

❑ Primary Advantage - Freedom ❑ Primary Advantage - Liberty

2. Please complete section below:

Office copayment: _____
Deductible: _____
Coinsurance (%): _____
Maximum out-of-pocket: _____
Emergency Room Copayment: _____

3. Please check additional riders selected:

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

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

Domestic Partner _____
90 Visits Physical Therapy: _____
SimplyEngaged® _____

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

IV. UNDERWRITING GUIDELINES

The undersigned authorized officer of the Company hereby acknowledges that if at any time the census data provided by the Company to Oxford, in conjunction with this Application for coverage does not accurately reflect, in the judgment of Oxford, the actual Company 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 Company, to increase the monthly premiums payable by the Company in such amount as is determined by Oxford, in its absolute discretion, to reflect the increased risk of such census variance. All statements made by the applicant are to be true and complete to the best of the applicant's knowledge and belief.

_____
Name of Company

X _____
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. 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.

I understand that the Certificate of Coverage or Summary Plan Description, and other documents, notices and communications regarding the coverage indicated on this application may be transmitted electronically to me and to the Applicant's employees. This consent remains in effect until it is withdrawn. The Applicant may withdraw their consent at any time or request a document in a paper or non-electronic form.

All statements made by the applicant are to be true and complete to the best of the applicant's knowledge and belief. 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_____.

_____

Company Name (Correct Legal Name)

X _____

Signature of Authorized Officer of the Company

Title of Officer of the Company

X _____

Witness

Duly Licensed Resident Agent/Broker