Oxford Health Plans®

Healthy New York Small Employer Group Application
Liberty Network

Oxford Health Plans (NY), Inc.

Mailing Address: 14 Central Park Drive, Hooksett, NH 03106

I. GENERAL INFORMATION

1. **Full legal name of firm:**

2. **Address of firm;**
(Street Address
City, State, Zip Code)
***No P.O. Box**

3. **Plan Administrator/Contact:**

   a. Name and Title

   b. Address:
   (Street Address
   City, State, Zip Code)
   (If it differs from address of firm; cannot be a P.O. Box)

   c. Phone Number:

   d. Fax Number:

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

   a. Name

   b. Title

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

   d. Phone Number:

   e. Fax Number:

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

6. **Nature of business:**

7. **SIC Code:**

8. **Tax identification number:**

II. EMPLOYER ELIGIBILITY

Please answer each question in the space provided. Most questions can be answered with a simple "Yes" or "No."

1. Is your business transferring from NYSHIPP, the Sure Access program or other regional pilot project for the uninsured?

_______ Yes
_______ No

If Yes, what was/will be the date of termination of this coverage? ___________________

2. Within the last twelve months, has your business provided (by both arranging for and contributing to the cost of the premium) for group health insurance covering your employees? (*Please see instructions for clarification.)

_______ Yes
_______ No

3. (a) Do you agree to contribute at least fifty percent of the cost of the Healthy New York premium on behalf of each of your employees?
(*Please note that employers must contribute at least fifty percent of the premium in order to be eligible for participation in the program. However, employers may choose to contribute up to 100% of the premium).

_______ Yes
_______ No

(b) What percentage of the Healthy New York premium will the employer be contributing? _______%
(c) What percentage of the premium will the employees be contributing? _______%

4. How many workers in total are employed by the business? ______

5. Do you intend to offer coverage to all persons included in item 4 above?

________ Yes
________ No

6. Do you intend to offer coverage only to employees earning $30,000 or less annually?

_________ Yes
_________ No

7. Important: The business must offer coverage to all employees working 20 or more hours weekly who earn $30,000 or less annually. The business may also offer coverage to persons earning more than $30,000 annually and to part-time workers (who work less than 20 hours weekly). In order to meet eligibility requirements, at least 30% of the employees offered coverage must earn $30,000 or less in annual wages.

(a) Of those workers who will be offered Healthy New York coverage, how many earn $30,000 or less annually? ___________

(b) Of those workers who will be offered Healthy New York coverage, how many earn more than $30,000 annually? ___________

(Note: If you do not wish to offer coverage to all persons in your employment, please see instruction sheet for a description of the rules applicable to establishing classes of employees to be offered coverage.)

(c) Total number of workers to be offered coverage: ___________
(Add the number from (a) & (b) above)

8. Do you intend to offer coverage to dependents of employees?

_______ Yes
_______ No

9. How many employees will enroll with Oxford Health Plans? ___________

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: ____________ | **01** | ____________.

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

3. **Other group health or HMO coverage:** Indicate below other group health or HMO coverage, including Oxford Health Plans, which is still in force or which terminated within the past twelve months.

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

4. **Employee Eligibility:**

Are any classes excluded? ❑ Yes ❑ No If yes, indicate classes excluded: ______________________________

____

CLASS I

Definition of Class I ______________________________

____

i) Eligibility:

Coverage will become effective on the date the employee is hired.

ii) Termination:

Coverage will terminate on the date of termination of employment.

6. **Continuation of Coverage:** Are there any former employees who have been paying you for coverage since they stopped working for you?

(Either COBRA or State Continuation Provisions) ❑ Yes ❑ No

If yes, please specify who those individuals are:

Name Qualifying Event and Date

____

____

____

IV. EMPLOYEE INFORMATION

Complete the following table by printing or typing the requested information for EACH EMPLOYEE of the business to whom coverage will be offered,regardless of whether or not they are applying for insurance coverage (see question 7c). Please photocopy and attach additional sheets, as needed.

Employee Name Last First	**Social Security Number**	**Applying for Insurance**	**Annual Wages**
		❑ Yes ❑ No	❑ $30,000 or Less ❑ More than $30,000
		❑ Yes ❑ No	❑ $30,000 or Less ❑ More than $30,000
		❑ Yes ❑ No	❑ $30,000 or Less ❑ More than $30,000
		❑ Yes ❑ No	❑ $30,000 or Less ❑ More than $30,000
		❑ Yes ❑ No	❑ $30,000 or Less ❑ More than $30,000
		❑ Yes ❑ No	❑ $30,000 or Less ❑ More than $30,000
		❑ Yes ❑ No	❑ $30,000 or Less ❑ More than $30,000
		❑ Yes ❑ No	❑ $30,000 or Less ❑ More than $30,000
		❑ Yes ❑ No	❑ $30,000 or Less ❑ More than $30,000
		❑ Yes ❑ No	❑ $30,000 or Less ❑ More than $30,000
		❑ Yes ❑ No	❑ $30,000 or Less ❑ More than $30,000
		❑ Yes ❑ No	❑ $30,000 or Less ❑ More than $30,000
		❑ Yes ❑ No	❑ $30,000 or Less ❑ More than $30,000
		❑ Yes ❑ No	❑ $30,000 or Less ❑ More than $30,000
		❑ Yes ❑ No	❑ $30,000 or Less ❑ More than $30,000
		❑ Yes ❑ No	❑ $30,000 or Less ❑ More than $30,000
		❑ Yes ❑ No	❑ $30,000 or Less ❑ More than $30,000
		❑ Yes ❑ No	❑ $30,000 or Less ❑ More than $30,000
		❑ Yes ❑ No	❑ $30,000 or Less ❑ More than $30,000

V. HEALTHY NY PLAN DESIGN

1.	**Network:**	Liberty
2.	**Copayment:**	$20.00 $10.00 (prenatal & postnatal visits)
3.	**Pharmacy benefit:**	
	a. Generic:	$10.00 per 34 day supply of a generic drug prescriptions or refill
	Brand:	$20.00 per brand, plus the difference in cost between brand name drug and its generic equivalent
	b. Deductible:	$100.00 per member, per calendar year
	c. Maximum:	$3,000.00 per member, per calendar year
4.	**Inpatient facility copay:**	$500.00 per continous confinement
5.	**Outpatient surgery copay:**	$20.00 per incident
6.	**Emergency room copay**:	$50.00 per visit
7.	**Outpatient/Ambulatory Surgical Center Services Facility copay**:	$75.00 per visit

VI. RATE INFORMATION

Monthly Rates: All new groups are subject to the 4 tier rate structure indicated below. Rates must be included in the spaces below for application processing.

	Single	EE/Spouse	EE/Child[ren]	Family
$				

VII. BROKER/AGENT INFORMATION

		BROKER	GENERAL AGENT
1.	**Full legal name of Broker/Agent:**		
2.	**Oxford Broker ID Code-*Required***		
3.	**Social Security # or Fed. Tax ID:**		
4.	**Address:**		
5.	**Telephone Number:**		
6.	**Fax Number:**		
7.	**Email address:**		
8.	**Oxford Sales Representative**		

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 selection of benefits 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 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 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 group health coverage terminated within the past 12 months due to failure to pay premiums.

Dated at:____________________this____________________day of________________________ 20__________.

(Full Legal Company Name)

IX. CERTIFICATION STATEMENT

By signing this certification of eligibility, I certify under penalty of perjury that all statements contained in this application are true and accurate to the best of my knowledge. I further certify that I am an officer of the business and that I am duly authorized to execute this certification on behalf of the business.

I understand that any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation

X

Signature of Authorized Officer of the Company | Title

Witness | Duly Licensed Resident Agent/Broker