



**PROFESSIONAL GROUP PLANS, INC.**  
*Specializing in Employee Benefits*

**Oxford Health Plans  
METRO/Direct/EPO/My Plan  
New Business Submission  
Checklist**

- Oxford Metro/Direct/EPO/My Plan Group Application**
- New York Enrollment Form(s)**
- Notice of Enrollment Periods & Waiver Form(s)  
(only when enrolling 1 employee)**
- Group Qualification Document (NYS-45, K-1, etc...)**
- First Month's Premium Check Payable to:  
Oxford Health Plans**
- Forms Must Be Submitted to PGP Office**  
3 days prior to the effective date.

**First time case submission needs licensing forms.**

**If you have any questions please contact your PGP representative.**

Updated 03/11/04



Freedom Plan<sup>®</sup> Metro<sup>SM</sup>      Oxford MyPlan<sup>SM</sup>  
 Liberty Plan Metro<sup>SM</sup>      Oxford HSA Exclusive<sup>SM</sup>  
 Freedom Plan<sup>®</sup> Metro<sup>SM</sup> Access      Oxford HSA Direct<sup>SM</sup>  
 Liberty Plan Metro<sup>SM</sup> Access  
 Oxford Exclusive Plan<sup>SM</sup> Metro  
 Freedom Plan<sup>®</sup> Direct<sup>SM</sup>  
 Liberty Plan Direct<sup>SM</sup>

# NY Small Group Application – OHI

Oxford Health Insurance Inc. • www.oxfordhealth.com

Mailing Address: Group Enrollment Department, 14 Central Park Drive, Hooksett, NH 03106

## I. GENERAL INFORMATION

1. Full Legal Name of Group:

2. Primary Address of Group:   
(Street Address  
 City, State, Zip Code)  
 \*No P.O. Box

3. Plan Administrator/Contact:

a. Name

b. Title

c. Address   
(if different from primary)  
 City, State, Zipcode

d. Phone Number    Ext.

e. Fax Number

f. E-mail Address

g. Add'l Contact & Number

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

a. Name

b. Title

c. Address   
(if different from primary)  
 City, State, Zipcode

d. Phone Number    Ext.

e. Fax Number

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

6. Nature of Business:

7. SIC Code:

8. Tax Identification Number:

## 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: \_\_\_\_\_  
(Month / Day 1<sup>st</sup> or 15<sup>th</sup> / Year)
2. **Anniversary date:** If the initial effective date is the 15th of the month, then the anniversary date is the first of the month following the effective date month.
3. **Open enrollment period:** The open enrollment period is the month prior to your anniversary date. The open enrollment effective date is the first of the month following the period.
4. **Total Number of Employees:** \_\_\_\_\_
5. **Employee Eligibility:** All full-time, permanent employees who work at least \_\_\_\_\_ hours per week (minimum 20 hours/week) are eligible.
6. **Number of Current Eligible Employees:** \_\_\_\_\_
7. **Number of Employees** enrolling with Oxford with the new group application \_\_\_\_\_
8. **Number of Waivers** for health coverage submitted \_\_\_\_\_
9. **Continuation of Coverage:** Are you enrolling any former employees under COBRA or State Continuation Provisions?  Yes  No  
 If yes, how many? \_\_\_\_\_
10. **Other group health or HMO coverage:** Indicate below other group health coverage which is still in force or which terminated within the past three years.

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

**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).**

**11. Integration with Medicare Benefits:** Health Benefits covered by Medicare Part A and B are carved out for Retired Employees age 65 or over and their dependents age 65 or over if the group offers retiree coverage.

### CLASS I

**Definition of Class I** \_\_\_\_\_

**i) Eligibility/Termination**

- Date on which the employee completes \_\_\_\_\_ days/months (circle one) of continuous service.  
 Termination will be the date of termination of employment.

**ii) Eligibility/Termination**

- On the first day of the calendar month coinciding with or next following the date on which the employee completes \_\_\_\_\_ days/months (circle one) of continuous service.  
 Termination will be on the last day of the calendar month

**iii) Waiting Period for Rehires**

- Waiting Period Waived for Rehires?  Yes  No  
 If yes, waived if rehired within \_\_\_\_\_ months.

### CLASS II

**Definition of Class II** \_\_\_\_\_

**i) Eligibility/Termination**

- Date on which the employee completes \_\_\_\_\_ days/months (circle one) of continuous service.  
 Termination will be the date of termination of employment.

**ii) Eligibility/Termination**

- On the first day of the calendar month coinciding with or next following the date on which the employee completes \_\_\_\_\_ days/months (circle one) of continuous service.  
 Termination will be on the last day of the calendar month

**iii) Waiting Period for Rehires**

- Waiting Period Waived for Rehires?  Yes  No  
 If yes, waived if rehired within \_\_\_\_\_ months.

## II. ADMINISTRATIVE INFORMATION (CON'T)

### CLASS III

Definition of Class III \_\_\_\_\_

**i) Eligibility/Termination**

Date on which the employee completes \_\_\_\_\_ days/months (circle one) of continuous service.

Termination will be the date of termination of employment.

**ii) Eligibility/Termination**

On the first day of the calendar month coinciding with or next following the date on which the employee completes \_\_\_\_\_ days/months (circle one) of continuous service.

Termination will be on the last day of the calendar month

**iii) Waiting Period for Rehires**

Waiting Period Waived for Rehires?  Yes  No

If yes, waived if rehired within \_\_\_\_\_ months.

### CLASS V

Definition of Class V \_\_\_\_\_

**i) Eligibility/Termination**

Date on which the employee completes \_\_\_\_\_ days/months (circle one) of continuous service.

Termination will be the date of termination of employment.

**ii) Eligibility/Termination**

On the first day of the calendar month coinciding with or next following the date on which the employee completes \_\_\_\_\_ days/months (circle one) of continuous service.

Termination will be on the last day of the calendar month

**iii) Waiting Period for Rehires**

Waiting Period Waived for Rehires?  Yes  No

If yes, waived if rehired within \_\_\_\_\_ months.

### CLASS IV

Definition of Class IV \_\_\_\_\_

**i) Eligibility/Termination**

Date on which the employee completes \_\_\_\_\_ days/months (circle one) of continuous service.

Termination will be the date of termination of employment.

**ii) Eligibility/Termination**

On the first day of the calendar month coinciding with or next following the date on which the employee completes \_\_\_\_\_ days/months (circle one) of continuous service.

Termination will be on the last day of the calendar month

**iii) Waiting Period for Rehires**

Waiting Period Waived for Rehires?  Yes  No

If yes, waived if rehired within \_\_\_\_\_ months.

### CLASS VI

Definition of Class VI \_\_\_\_\_

**i) Eligibility/Termination**

Date on which the employee completes \_\_\_\_\_ days/months (circle one) of continuous service.

Termination will be the date of termination of employment.

**ii) Eligibility/Termination**

On the first day of the calendar month coinciding with or next following the date on which the employee completes \_\_\_\_\_ days/months (circle one) of continuous service.

Termination will be on the last day of the calendar month

**iii) Waiting Period for Rehires**

Waiting Period Waived for Rehires?  Yes  No

If yes, waived if rehired within \_\_\_\_\_ months.

### III. PRODUCT AND PLAN DESIGNS (CONTINUED)

#### C. Oxford Exclusive Plan<sup>SM</sup> Metro (Non-gated - No referrals required)

Instructions: Please select a plan option and check off any variable items as provided below.

Please Select Network:  Freedom<sup>®</sup>  Liberty<sup>SM</sup>

Options	<input type="checkbox"/> Plan 1	<input type="checkbox"/> Plan 2	<input type="checkbox"/> Plan 3	<input type="checkbox"/> Plan 4	<input type="checkbox"/> Plan 5	<input type="checkbox"/> Plan 6
<b>Copayment:</b>						
a. PCP	\$15 per visit	\$25 per visit	\$15 per visit	\$25 per visit	\$25 per visit	\$20 per visit
b. Specialist	\$30 per visit	\$50 per visit	\$30 per visit	\$50 per visit	\$50 per visit	\$40 per visit
<b>Single Deductible</b>	none	none	\$1,000	\$1,000	\$2,000	N/A
<b>Family Deductible</b>	none	none	\$2,000	\$2,000	\$4,000	N/A
<b>Coinsurance</b>	none	none	80% to \$10,000/\$20,000	90% to \$10,000/\$20,000	90% to \$10,000/\$20,000	N/A
<b>Outpatient Facility Copayment</b>	\$150 per incident	\$300 per incident	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	\$200 per incident
<b>Inpatient Facility Copayment</b>	\$150 per continuous confinement	\$300 per day to five day maximum	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	\$200 per continuous confinement
<b>Emergency Room</b>	\$75	\$75	\$75	\$75	\$75	\$75

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

Additional Benefit Options:

- Vision       Dental Enhanced       Dental Premium       Other: \_\_\_\_\_  
 Age 25 Dependent Student Cutoff (Age 23 is standard)      Subject to Home Office Approval  
**Note:** Cutoff must match for all plan designs selected  
 Domestic Partner  
 Coverage for Biologically Based Mental Illness and Children with Serious Emotional Disturbances

Please select optional prescription drug coverage:

Options	Tier 1	Tier 2	Tier 3	Mail-Order	Deductible** (Please select one)
<input type="checkbox"/> Option 1	\$10 copayment	\$25 copayment	\$50 copayment	2x copayment	<input type="checkbox"/> \$50 <input type="checkbox"/> \$100
<input type="checkbox"/> Option 2	\$15 copayment	50%	50%	2x copayment or 50%	<input type="checkbox"/> \$50 <input type="checkbox"/> \$100
<input type="checkbox"/> Option 3*	\$15 copayment	\$30 copayment	\$60 copayment	\$30/\$60/\$180	\$100 (Required)
<input type="checkbox"/> Option 4	\$15 copayment	\$35 copayment	\$75 copayment	2x copayment	<input type="checkbox"/> \$50 <input type="checkbox"/> \$100
<input type="checkbox"/> Waived Coverage	N/A	N/A	N/A	N/A	N/A

\* This pharmacy plan has a maximum per contract year of \$3,000, applicable to all drugs.

\*\* Deductible applies to Tier 2 and Tier 3 drugs.

Contraceptives:

- Yes (Standard)       No (Qualified State Exempt Groups Only)

Medicare Part D 28% Subsidy - For the Rx plan design above, do you currently participate or plan to participate with the 28% Government Subsidy for your Medicare eligible retirees?  Yes  No

**III. PRODUCT AND PLAN DESIGNS (CONTINUED)**

**D. Oxford Ease<sup>SM</sup> (Non-gated – No referrals required)**

Please Select Network:  Freedom<sup>®</sup>  Liberty<sup>SM</sup>

<b>Options</b>	<input type="checkbox"/> <b>Plan 1</b>
<b>Copayment:</b> a. PCP b. Specialist	\$50 per visit \$50 per visit
<b>Single Deductible</b>	N/A
<b>Family Deductible</b>	N/A
<b>Coinsurance</b>	N/A
<b>Outpatient Facility Copayment</b>	\$500 per incident
<b>Inpatient Facility Copayment</b>	\$500 per day, to max of \$5,000, per calendar year
<b>Emergency Room</b>	\$150

**Additional Benefit Options:**  Vision  Dental Enhanced  Dental Premium  Other: \_\_\_\_\_  
 Age 25 Dependent Student Cutoff (Age 23 is standard) Subject to Home Office Approval  
**Note:** Cutoff must match for all plan designs selected  
 Domestic Partner  
 Coverage for Biologically Based Mental Illness and Children with Serious Emotional Disturbances

**Please select optional prescription drug coverage:**

Options	Tier 1	Tier 2	Tier 3	Mail-Order	Deductible* (Please select one)
<input type="checkbox"/> Option 1	\$15 copayment	\$35 copayment	\$75 copayment	2x copayment	<input type="checkbox"/> \$50 <input type="checkbox"/> \$100
<input type="checkbox"/> Waived Coverage	N/A	N/A	N/A	N/A	N/A

\* Deductible applies to Tier 2 and Tier 3 drugs.

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

Medicare Part D 28% Subsidy – For the Rx plan design above, do you currently participate or plan to participate with the 28% Government Subsidy for your Medicare eligible retirees?  Yes  No

### III. PRODUCT AND PLAN DESIGNS (CONTINUED)

#### C. Oxford Exclusive Plan<sup>SM</sup> Metro (Non-gated - No referrals required)

Instructions: Please select a plan option and check off any variable items as provided below.

Please Select Network:  Freedom<sup>®</sup>  Liberty<sup>SM</sup>

Options	<input type="checkbox"/> Plan 1	<input type="checkbox"/> Plan 2	<input type="checkbox"/> Plan 3	<input type="checkbox"/> Plan 4	<input type="checkbox"/> Plan 5
<b>Copayment:</b>					
a. PCP	\$15 per visit	\$25 per visit	\$15 per visit	\$25 per visit	\$25 per visit
b. Specialist	\$30 per visit	\$50 per visit	\$30 per visit	\$50 per visit	\$50 per visit
<b>Single Deductible</b>	none	none	\$1,000	\$1,000	\$2,000
<b>Family Deductible</b>	none	none	\$2,000	\$2,000	\$4,000
<b>Coinsurance</b>	none	none	80% to \$10,000/\$20,000	90% to \$10,000/\$20,000	90% to \$10,000/\$20,000
<b>Outpatient Facility Copayment</b>	\$150 per incident	\$300 per incident	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
<b>Inpatient Facility Copayment</b>	\$150 per continuous confinement	\$300 per day to five day maximum	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
<b>Emergency Room</b>	\$75	\$75	\$75	\$75	\$75

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

**Additional Benefit Options:**  Vision  Dental Enhanced  Dental Premium  Other: \_\_\_\_\_ Subject to Home Office Approval  
 Age 25 Dependent Student Cutoff (Age 23 is standard)  
**Note:** Cutoff must match for all plan designs selected  
 Domestic Partner  
 Coverage for Biologically Based Mental Illness and Children with Serious Emotional Disturbances

Please select optional prescription drug coverage:

Options	Tier 1	Tier 2	Tier 3	Mail-Order	Deductible** (Please select one)
<input type="checkbox"/> Option 1	\$10 copayment	\$25 copayment	\$50 copayment	2x copayment	<input type="checkbox"/> \$50 <input type="checkbox"/> \$100
<input type="checkbox"/> Option 2	\$15 copayment	50%	50%	2x copayment or 50%	<input type="checkbox"/> \$50 <input type="checkbox"/> \$100
<input type="checkbox"/> Option 3*	\$15 copayment	\$30 copayment	\$60 copayment	\$30/\$60/\$180	\$100 (Required)
<input type="checkbox"/> Waived Coverage	N/A	N/A	N/A	N/A	N/A

\* This pharmacy plan has a maximum per contract year of \$3,000, applicable to all drugs.

\*\* Deductible applies to Tier 2 and Tier 3 drugs.

**Contraceptives:**

Yes (Standard)  No (Qualified State Exempt Groups Only)

Medicare Part D 28% Subsidy - For the Rx plan design above, do you currently participate or plan to participate with the 28% Government Subsidy for your Medicare eligible retirees?  Yes  No

### III. PRODUCT AND PLAN DESIGNS (CONTINUED)

#### E. Oxford MyPlan<sup>SM</sup>

Please note: Groups enrolling in the Oxford MyPlan must also fill out an Oxford MyPlan<sup>SM</sup> Health Reserve Account Group Application Form (#6740).

Please Select Network:  Freedom<sup>®</sup>  Liberty<sup>SM</sup>

No referrals are required for these plan designs.

#### In-Network/Out-of-Network

Please select a plan type:

Options	<input type="checkbox"/> Plan 1	<input type="checkbox"/> Plan 2	<input type="checkbox"/> Plan 3
<b>Copayment</b>	\$25 PCP \$40 Specialist	N/A	N/A
<b>Single Deductible</b>	\$1,000/\$2,000	\$1,000/\$2,000	\$2,000/\$2,000
<b>Family Deductible</b>	\$2,000/\$4,000	\$2,000/\$4,000	\$4,000/\$4,000
<b>Coinsurance</b>	80%/60%	80%/60%	90%/70%
<b>Out-of-Network Reimbursement</b>	<input type="checkbox"/> 150% of Medicare rate <input type="checkbox"/> 70% UCR	<input type="checkbox"/> 150% of Medicare rate <input type="checkbox"/> 70% UCR	<input type="checkbox"/> 150% of Medicare rate <input type="checkbox"/> 70% UCR
<b>Single Maximum Out-of-Pocket</b>	\$3,000/\$6,000	\$3,000/\$6,000	\$3,000/\$5,000
<b>Family Maximum Out-of-Pocket</b>	\$6,000/\$12,000	\$6,000/\$12,000	\$6,000/\$10,000

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

#### Additional Benefit Options:

- Vision  Dental Enhanced  Dental Premium  
 Age 25 Dependent Student Cutoff (Age 23 is standard)  
**Note:** Cutoff must match for all plan designs selected.  
 Domestic Partner  
 Coverage for Biologically Based Mental Illness and Children with Serious Emotional Disturbances

Please select optional prescription drug coverage:

Options	Tier 1	Tier 2	Tier 3	Mail-Order	Deductible ** (Please select one)
<input type="checkbox"/> Option 1	\$10 copayment	\$25 copayment	\$50 copayment	2x copayment	\$50 (Required)
<input type="checkbox"/> Option 2	\$15 copayment	50%	50%	2x copayment or 50%	\$50 (Required)
<input type="checkbox"/> Option 3*	\$15 copayment	\$30 copayment	\$60 copayment	\$30/\$60/\$180	\$100 (Required)
<input type="checkbox"/> Waived Coverage	N/A	N/A	N/A	N/A	N/A

\*This pharmacy plan has a maximum per contract year of \$3,000, applicable to all drugs.

\*\* Deductible applies to Tier 2 and Tier 3 drugs.

#### Contraceptives:

- Yes (Standard)  No (Qualified State Exempt Groups Only)

Medicare Part D 28% Subsidy - For the Rx plan design above, do you currently participate or plan to participate with the 28% Government Subsidy for your Medicare eligible retirees?  Yes  No

# III. PRODUCT AND PLAN DESIGNS (CONTINUED)

## F. Oxford HSA Exclusive<sup>SM</sup>

**Please note:** Groups enrolling in the Oxford HSA Exclusive must also fill out an Oxford HSA Bank Notification Form (#7423).

Please Select Network:  Freedom<sup>®</sup>  Liberty<sup>SM</sup>

No referrals are required for these plan designs.

**In-Network Only**

Options	<input type="checkbox"/> Plan 1	<input type="checkbox"/> Plan 2	<input type="checkbox"/> Plan 3
Single Deductible **	\$1,250	\$2,000	\$2,850
Family Deductible **	\$2,500	\$4,000	\$5,700
Coinsurance	100%	100%	100%
Single Medical Maximum Out-of-Pocket	\$1,250	\$2,000	\$2,850
Family Medical Maximum Out-of-Pocket	\$2,500	\$4,000	\$5,700

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

Please select prescription drug coverage: **\*\* (Required)**

Options	Tier 1	Tier 2	Tier 3	Mail-Order
<input type="checkbox"/> Option 1	\$10 copayment	\$25 copayment	\$50 copayment	2x copayment
<input type="checkbox"/> Option 2	\$15 copayment	50%	50%	2x copayment or 50%

Contraceptives:

Yes (Standard)       No (Qualified State Exempt Groups Only)

**\*\*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 copay will apply based on the option selected at plan inception. No individual on a multiple person contract may satisfy the individual deductible and maximum out-of-pocket until the entire family deductible or maximum out-of-pocket have been met. Out-of-network benefits are accumulated separately.

Medicare Part D 28% Subsidy - For the Rx plan design above, do you currently participate or plan to participate with the 28% Government Subsidy for your Medicare eligible retirees?  Yes     No

**Additional Benefit Options:**

- Vision       Dental Enhanced     Dental Premium     Other: \_\_\_\_\_  
SUBJECT TO HOME OFFICE APPROVAL  
 Age 25 Dependent Student Cutoff (Age 23 is standard)  
**Note:** Cutoff must match for all plan designs selected  
 Domestic Partner  
 Coverage for Biologically Based Mental Illness and Children with Serious Emotional Disturbances

### III. PRODUCT AND PLAN DESIGNS (CONTINUED)

#### B. Freedom Plan Metro Access and Liberty Plan Metro Access (Non-gated - No referrals required)

Instructions: Please select a network; plan option and any additional benefit options as provided below.

Please Select Network:  Freedom<sup>®</sup>  Liberty<sup>SM</sup>

Options	<input type="checkbox"/> Metro Plan Access Option 1	<input type="checkbox"/> Metro Plan Access Option 2
Office visit copayment:	\$20 PCP/\$30 specialist	\$30 PCP/\$50 specialist
Hospital copayment	\$500 per admission per continuous confinement	\$500 per admission per continuous confinement
Outpatient/Hospital Ambulatory surgery	\$250 copayment	\$500 copayment
Out-of-Network deductible - Single/Family	\$2,000/\$6,000	\$3,000/\$9,000
Out-of-Network coinsurance - Single/Family	70% to \$10,000/\$30,000	70% to \$10,000/\$30,000
Out-of-Network reimbursement	<input type="checkbox"/> 150% of Medicare rate <input type="checkbox"/> 70% UCR	<input type="checkbox"/> 150% of Medicare rate <input type="checkbox"/> 70% UCR

Deductibles and out-of-pocket accumulators are on a calendar year basis.

Additional Benefit Options:  Vision  Dental Enhanced  Dental Premium  Other: \_\_\_\_\_

SUBJECT TO HOME OFFICE APPROVAL

Age 25 Dependent Student Cutoff (Age 23 is standard)

**Note:** Cutoff must match for all plan designs selected.

Domestic Partner

Coverage for Biologically Based Mental Illness and Children with Serious Emotional Disturbances

Please select optional prescription drug coverage:

Options	Tier 1	Tier 2	Tier 3	Mail-Order	Deductible ** (Please select one)
<input type="checkbox"/> Option 1	\$10 copayment	\$25 copayment	\$50 copayment	2x copayment	<input type="checkbox"/> \$50 <input type="checkbox"/> \$100 <input type="checkbox"/> \$250 <input type="checkbox"/> \$500
<input type="checkbox"/> Option 2	\$15 copayment	50%	50%	2x copayment or 50%	<input type="checkbox"/> \$50 <input type="checkbox"/> \$100 <input type="checkbox"/> \$250 <input type="checkbox"/> \$500
<input type="checkbox"/> Option 3*	\$15 copayment	\$30 copayment	\$60 copayment	\$30/\$60/\$180	\$100 (Required)
<input type="checkbox"/> Waived Coverage	N/A	N/A	N/A	N/A	N/A

\* This pharmacy plan has a maximum per contract year of \$3,000, applicable to all drugs.

\*\* Deductible applies to Tier 2 and Tier 3 drugs.

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

Medicare Part D 28% Subsidy - For the Rx plan design above, do you currently participate or plan to participate with the 28% Government Subsidy for your Medicare eligible retirees?  Yes  No

### III. PRODUCT AND PLAN DESIGNS (CONTINUED)

#### D. Freedom Plan<sup>®</sup> Direct<sup>SM</sup> and Liberty Plan Direct<sup>SM</sup>

No referrals are required for these plan designs.

#### In-Network/Out-of-Network

Please Select Network:  Freedom<sup>®</sup>  Liberty<sup>SM</sup>

Options	<input type="checkbox"/> Plan 1	<input type="checkbox"/> Plan 2	<input type="checkbox"/> Plan 3	<input type="checkbox"/> Plan 4	<input type="checkbox"/> Plan 5	<input type="checkbox"/> Plan 6	<input type="checkbox"/> Plan 7	<input type="checkbox"/> Plan 8	<input type="checkbox"/> Plan 9	<input type="checkbox"/> Plan 10
<b>Copayment</b>	\$15 PCP / \$25 Specialist	\$25 PCP / \$40 Specialist	\$25 PCP / \$40 Specialist	\$30 PCP / \$50 Specialist	N/A	N/A	N/A	\$15 PCP / \$25 Specialist	\$25 PCP / \$40 Specialist	\$25 PCP / \$40 Specialist
<b>Single Deductible</b>	\$500/\$1,000	\$500/\$1,000	\$1,000/\$2,000	\$2,000/\$2,000	\$500/\$1,000	\$2,000/\$2,000	\$1,000/\$2,000	\$1,000/\$2,000	\$500/\$1,000	\$1,000/\$2,000
<b>Family Deductible</b>	\$1,000/\$2,000	\$1,000/\$2,000	\$2,000/\$4,000	\$4,000/\$4,000	\$1,000/\$2,000	\$4,000/\$4,000	\$2,000/\$4,000	\$2,000/\$4,000	\$1,000/\$2,000	\$2,000/\$4,000
<b>Coinsurance</b>	90%/70%	80%/60%	80%/60%	80%/60%	90%/70%	90%/70%	80%/60%	100%/70%	100%/70%	100%/70%
<b>Out-of-Network</b>	<input type="checkbox"/> 150% of Medicare rate / <input type="checkbox"/> 70% UCR	<input type="checkbox"/> 150% of Medicare rate / <input type="checkbox"/> 70% UCR	<input type="checkbox"/> 150% of Medicare rate / <input type="checkbox"/> 70% UCR	<input type="checkbox"/> 150% of Medicare rate / <input type="checkbox"/> 70% UCR	<input type="checkbox"/> 150% of Medicare rate / <input type="checkbox"/> 70% UCR	<input type="checkbox"/> 150% of Medicare rate / <input type="checkbox"/> 70% UCR	<input type="checkbox"/> 150% of Medicare rate / <input type="checkbox"/> 70% UCR	<input type="checkbox"/> 150% of Medicare rate / <input type="checkbox"/> 70% UCR	<input type="checkbox"/> 150% of Medicare rate / <input type="checkbox"/> 70% UCR	<input type="checkbox"/> 150% of Medicare rate / <input type="checkbox"/> 70% UCR
<b>Single Maximum Out-of-Pocket</b>	\$1,500/\$4,000	\$2,500/\$5,000	\$3,000/\$6,000	\$4,000/\$8,000	\$1,500/\$4,000	\$3,000/\$5,000	\$3,000/\$6,000	\$3,000/\$6,000	\$1,500/\$4,000	\$3,000/\$6,000
<b>Family Maximum Out-of-Pocket</b>	\$3,000/\$8,000	\$5,000/\$10,000	\$6,000/\$12,000	\$8,000/\$16,000	\$3,000/\$8,000	\$6,000/\$10,000	\$6,000/\$12,000	\$6,000/\$12,000	\$3,000/\$8,000	\$6,000/ \$12,000

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

#### Additional Benefit Options:

Vision  Dental Enhanced  Dental Premium

Other: \_\_\_\_\_

Age 25 Dependent Student Cutoff (Age 23 is standard)

SUBJECT TO HOME OFFICE APPROVAL

**Note:** Cutoff must match for all plan designs selected.

Domestic Partner

Coverage for Biologically Based Mental Illness and Children with Serious Emotional Disturbances

#### Please select optional prescription drug coverage:

Options	Tier 1	Tier 2	Tier 3	Mail-Order	Deductible ** (Please select one)
<input type="checkbox"/> Option 1	\$10 copayment	\$25 copayment	\$50 copayment	2x copayment	<input type="checkbox"/> \$50 <input type="checkbox"/> \$100 <input type="checkbox"/> \$150 <input type="checkbox"/> \$250
<input type="checkbox"/> Option 2	\$15 copayment	50%	50%	2x copayment or 50%	<input type="checkbox"/> \$50 <input type="checkbox"/> \$100 <input type="checkbox"/> \$150 <input type="checkbox"/> \$250
<input type="checkbox"/> Option 3*	\$15 copayment	\$30 copayment	\$60 copayment	\$30/\$60/\$180	\$100 (Required)
<input type="checkbox"/> Waived Coverage	N/A	N/A	N/A	N/A	N/A

\* This pharmacy plan has a maximum per contract year of \$3,000, applicable to all drugs.

\*\* Deductible applies to Tier 2 and Tier 3 drugs.

#### Contraceptives:

Yes (Standard)

No (Qualified State Exempt Groups Only)

Medicare Part D 28% Subsidy - For the Rx plan design above, do you currently participate or plan to participate with the 28% Government Subsidy for your Medicare eligible retirees?  Yes  No

### III. PRODUCT AND PLAN DESIGNS (CONTINUED)

#### G. Oxford HSA Direct<sup>SM</sup>

**Please note:** Groups enrolling in the Oxford HSA Direct must also fill out an Oxford HSA Bank Notification Form (#7423).

**Please Select Network:**  Freedom<sup>®</sup>  Liberty<sup>SM</sup>

No referrals are required for these plan designs.

#### In-Network/Out-of-Network

Options	<input type="checkbox"/> Plan 1	<input type="checkbox"/> Plan 2	<input type="checkbox"/> Plan 3	<input type="checkbox"/> Plan 4	<input type="checkbox"/> Plan 5	<input type="checkbox"/> Plan 6
<b>Single Deductible **</b>	\$1,250/ \$2,000	\$2,000/ \$2,000	\$2,850/ \$2,850	\$1,250/ \$2,000	\$2,000/ \$2,000	\$2,850/ \$2,850
<b>Family Deductible **</b>	\$2,500/ \$4,000	\$4,000/ \$4,000	\$5,700/ \$5,700	\$2,500/ \$4,000	\$4,000/ \$4,000	\$5,700/ \$5,700
<b>Coinsurance</b>	80%/60%	90%/70%	90%/70%	100%/70%	100%/70%	100%/70%
<b>Single Medical Maximum Out-of-Pocket</b>	\$3,250/ \$6,000	\$3,000/ \$5,000	\$3,850/ \$5,850	\$1,250/ \$5,000	\$2,000/ \$5,000	\$2,850/ \$5,850
<b>Family Medical Maximum Out-of-Pocket</b>	\$6,500/ \$12,000	\$6,000/ \$10,000	\$7,700/ \$11,700	\$2,500/ \$10,000	\$4,000/ \$10,000	\$5,700/ \$11,700

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

#### Additional Benefit Options:

Vision  Dental Enhanced  Dental Premium

Other: \_\_\_\_\_

Age 25 Dependent Student Cutoff (Age 23 is standard)

SUBJECT TO HOME OFFICE APPROVAL

**Note:** Cutoff must match for all plan designs selected.

Domestic Partner

Coverage for Biologically Based Mental Illness and Children with Serious Emotional Disturbances

#### Please select optional prescription drug coverage: \*\* (Required)

Options	Tier 1	Tier 2	Tier 3	Mail-Order
<input type="checkbox"/> Option 1	\$10 copayment	\$25 copayment	\$50 copayment	2x copayment
<input type="checkbox"/> Option 2	\$15 copayment	50%	50%	2x copayment or 50%

#### Contraceptives:

Yes (Standard)

No (Qualified State Exempt Groups Only)

**\*\*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 copay will apply based on the option selected at plan inception. Out-of-network benefits are accumulated separately. No individual on a multiple person contract may satisfy the individual deductible and maximum out-of-pocket until the entire family deductible or maximum out-of-pocket have been met.

Medicare Part D 28% Subsidy - For the Rx plan design above, do you currently participate or plan to participate with the 28% Government Subsidy for your Medicare eligible retirees?  Yes  No

**VII. COBRA & 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? \_\_\_\_\_

**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 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 group health policy terminated within the past 12 months due to failure to pay premiums.

Dated at: \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_\_.

**Full legal name of firm:** \_\_\_\_\_

The above named company confirms that we employ no more than 50 full-time, non-union employees.

Any person who knowingly and with 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 \$5,000 dollars and the stated value of the claim for each such violation.

Oxford Health Insurance, Inc.

**X**

Signature of Authorized Officer of the Company

Title

Witness

Duly Licensed Resident Agent/Broker

## IV. RATE INFORMATION

**Monthly Rates:** All new groups are subject to the four-tier rate structure indicated below. Rates must be included in the spaces below for application processing. Please note: All four categories must be completed.

Single	Couple	Parent/Children	Family
\$ _____	\$ _____	\$ _____	\$ _____

## V. 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. 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](http://www.oxfordhealth.com). For specific information about the compensation payable with respect to your particular policy, please contact your producer.

## 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 Oxford 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).

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.



A UnitedHealthcare Company

## New York Member Enrollment Form - OHI

Mailing Address: P.O. Box 7085, Bridgeport, CT 06601 • [www.oxfordhealth.com](http://www.oxfordhealth.com)

Thank you for choosing Oxford Health Plans as the health plan for you and your family.

### IMPORTANT!

In order to process the attached Member Enrollment form and begin coverage, all of the following information must be completed accurately and in its entirety:  
**INCOMPLETE FORMS WILL BE RETURNED.**

#### By the Employer

- ✍ Group Number
- ✍ Contract Specific Package (CSP)
- ✍ Billing Group (BG)
- ✍ Date of Full-Time Employment
- ✍ Employer Signature
- ✍ Effective Date of Coverage

#### By the Employee

- ✍ Date of Marriage
- ✍ Date of Birth
- ✍ Social Security Numbers
- ✍ Primary Care Physician selections (Freedom Plan Access, Liberty Plan Access, Freedom Plan Direct and Liberty Plan Direct, no PCP selection is required)
- ✍ Information on other coverage that you or your spouse may have
- ✍ Signature at the bottom of the form
- ✍ Mailing Address, including Zip Code

\* Preexisting condition limitations apply to all Members with gaps in coverage of greater than 63 days in the 12 months prior to the Member's Enrollment Date. Please complete the enclosed "Health Coverage History Form."

**Note: Please press down firmly when completing this form.**

If you have any questions, please feel free to call our Member Service Department at 800-444-6222 or 203-852-1442. Thank you for your cooperation.



A UnitedHealthcare Company

# New York Member Enrollment Form - OHI

Mailing Address: P.O. Box 7085, Bridgeport, CT 06601 • www.oxfordhealth.com

Please do not write in this area, for Oxford use only.

To Be Completed By EMPLOYER				(Please Print)
NAME OF GROUP (EMPLOYER)		GROUP NUMBER	CONTRACT SPECIFIC PACKAGE (CSP)	BILLING GROUP (BG)
EMPLOYEE'S EFFECTIVE DATE OF COVERAGE MO. DAY YEAR		IS INDIVIDUAL COVERED UNDER COBRA? IF YES, QUALIFYING EVENT <input type="checkbox"/> YES <input type="checkbox"/> NO		DATE OF QUALIFYING EVENT MO. DAY YEAR
DATE OF FULL-TIME EMPLOYMENT MO. DAY YEAR		AVERAGE NO. OF HOURS WORKED PER WEEK	EMPLOYEE OCCUPATION: <input type="checkbox"/> EXECUTIVE <input type="checkbox"/> MANAGEMENT <input type="checkbox"/> NON-MANAGEMENT <input type="checkbox"/> HOURLY <input type="checkbox"/> OTHER (PLEASE SPECIFY)	EMPLOYEE CLASSIFICATION <input type="checkbox"/> UNION <input type="checkbox"/> NON-UNION
X EMPLOYER SIGNATURE				DATE

To Be Completed By EMPLOYEE				(Please Print)
SOCIAL SECURITY NO.		LAST NAME		
FIRST NAME	MI	BIRTH DATE MO. DAY YEAR	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	HOME PHONE ( ) BUSINESS PHONE ( )
STREET ADDRESS		APT. NO.	CITY	STATE ZIP
WILL YOU HAVE ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, CARRIER NAME		NAME OF POLICY HOLDER		POLICY START DATE / /
OXFORD CODE OF PRIMARY CARE PHYSICIAN SELECTED		ARE YOU AN EXISTING PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	PRIOR HEALTH INSURANCE INFORMATION: CARRIER NAME	
OXFORD CODE OF OB/GYN SELECTED (Female Members)		ARE YOU AN EXISTING PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	COVERAGE BEGIN DATE / /	COVERAGE END DATE / /

EMPLOYEE'S Dependent Information				(Please Print)
SPOUSE'S SOCIAL SECURITY NUMBER		SPOUSE'S LAST NAME		SPOUSE'S FIRST NAME MI
SPOUSE'S BIRTH DATE MO. DAY YEAR		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF MARRIAGE MO. DAY YEAR	SPOUSE'S EMPLOYER
WILL YOU HAVE ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, CARRIER NAME		NAME OF POLICY HOLDER		POLICY START DATE / /
OXFORD CODE OF PRIMARY CARE PHYSICIAN SELECTED		ARE YOU AN EXISTING PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	PRIOR HEALTH INSURANCE INFORMATION: CARRIER NAME	
OXFORD CODE OF OB/GYN SELECTED (Female Members)		ARE YOU AN EXISTING PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	COVERAGE BEGIN DATE / /	COVERAGE END DATE / /
ELIGIBLE CHILD'S SOCIAL SECURITY NO.		ELIGIBLE CHILD'S LAST NAME		ELIGIBLE CHILD'S FIRST NAME MI <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
ELIGIBLE CHILD'S BIRTH DATE MO. DAY YEAR		IS THIS DEPENDENT DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO	WILL YOU HAVE ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD? <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, CARRIER NAME:	NAME OF POLICY HOLDER POLICY START DATE / /
OXFORD CODE OF PRIMARY CARE PHYSICIAN SELECTED		ARE YOU AN EXISTING PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	PRIOR HEALTH INSURANCE INFORMATION: CARRIER NAME	
OXFORD CODE OF OB/GYN SELECTED (Female Members)		ARE YOU AN EXISTING PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	COVERAGE BEGIN DATE / /	COVERAGE END DATE / /
ELIGIBLE CHILD'S SOCIAL SECURITY NO.		ELIGIBLE CHILD'S LAST NAME		ELIGIBLE CHILD'S FIRST NAME MI <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
ELIGIBLE CHILD'S BIRTH DATE MO. DAY YEAR		IS THIS DEPENDENT DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO	WILL YOU HAVE ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD? <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, CARRIER NAME:	NAME OF POLICY HOLDER POLICY START DATE / /
OXFORD CODE OF PRIMARY CARE PHYSICIAN SELECTED		ARE YOU AN EXISTING PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	PRIOR HEALTH INSURANCE INFORMATION: CARRIER NAME	
OXFORD CODE OF OB/GYN SELECTED (Female Members)		ARE YOU AN EXISTING PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	COVERAGE BEGIN DATE / /	COVERAGE END DATE / /
ELIGIBLE CHILD'S SOCIAL SECURITY NO.		ELIGIBLE CHILD'S LAST NAME		ELIGIBLE CHILD'S FIRST NAME MI <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
ELIGIBLE CHILD'S BIRTH DATE MO. DAY YEAR		IS THIS DEPENDENT DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO	WILL YOU HAVE ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD? <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, CARRIER NAME:	NAME OF POLICY HOLDER POLICY START DATE / /
OXFORD CODE OF PRIMARY CARE PHYSICIAN SELECTED		ARE YOU AN EXISTING PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	PRIOR HEALTH INSURANCE INFORMATION: CARRIER NAME	
OXFORD CODE OF OB/GYN SELECTED (Female Members)		ARE YOU AN EXISTING PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	COVERAGE BEGIN DATE / /	COVERAGE END DATE / /
ELIGIBLE CHILD'S SOCIAL SECURITY NO.		ELIGIBLE CHILD'S LAST NAME		ELIGIBLE CHILD'S FIRST NAME MI <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
ELIGIBLE CHILD'S BIRTH DATE MO. DAY YEAR		IS THIS DEPENDENT DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO	WILL YOU HAVE ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD? <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, CARRIER NAME:	NAME OF POLICY HOLDER POLICY START DATE / /
OXFORD CODE OF PRIMARY CARE PHYSICIAN SELECTED		ARE YOU AN EXISTING PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	PRIOR HEALTH INSURANCE INFORMATION: CARRIER NAME	
OXFORD CODE OF OB/GYN SELECTED (Female Members)		ARE YOU AN EXISTING PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	COVERAGE BEGIN DATE / /	COVERAGE END DATE / /

If you have additional dependents, please use another enrollment form to provide the necessary information. In order to help us quickly process this form and avoid delays, please make sure all areas are properly filled out.

I understand that my enrollments and benefits are in accordance with those described in the Oxford Health Insurance Certificate. I understand that, in order to receive in-network benefits, I and any enrolled dependents must seek care through our Oxford affiliated primary care physician or through an Oxford-affiliated specialist physician with an authorized referral from the primary care physician if required. I further understand that if I do not adhere to these requirements, I will be eligible only for out-of-network health insurance coverage under the terms of the Certificate.

Any person who knowingly and with 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 EMPLOYEE/APPLICANT SIGNATURE DATE





A UnitedHealthcare Company

# Student Verification Parent Affidavit Form

Mailing Address: P.O. Box 7085, Bridgeport, CT 06601-9688 • 1-800-444-6222

Welcome to Oxford Health Plans.

To be eligible for student dependent coverage we require verification of full-time student status, please submit verification for the current semester.

Please arrange to have this postage-paid Student Verification Information Form submitted to Oxford at the time of your enrollment.

If your child is not a full-time student, he or she may still be eligible for coverage. For more information, please contact the Benefits Administrator at your company.

If you have any questions, please call our Customer Service Department at 1-800-444-6222.

Sincerely,

Oxford Health Plans

**TO BE COMPLETED BY THE SUBSCRIBER**

Employer Name

Subscriber Name

Subscriber Social Security #

Name of Student

Student Social Security #

Name of School

Address

Phone

I confirm that the above named dependent is registered as a  full-time  part-time student at an accredited educational institution for the \_\_\_/\_\_\_/\_\_\_ semester, which begins on \_\_\_/\_\_\_/\_\_\_ and ends \_\_\_/\_\_\_/\_\_\_.

I attest that the information shown above is true and complete. I understand that failure to complete this form may result in delayed, denied or termination of coverage for the above named dependent. I understand that Oxford Health Plans reserves the right to request additional information as proof of the above-named dependent's full-time status.

Further, any person who knowingly and with intent to defraud an insurance company or other person files a statement or claim containing any materially false information concerning any material fact thereto, commits a fraudulent insurance act, which is a crime, and is also subject to a civil penalty.

Subscriber's Signature

Date



A UnitedHealthcare Company

## New York Member Enrollment Form - OHI

**Mailing Address:** P.O. Box 7085, Bridgeport, CT 06601 • [www.oxfordhealth.com](http://www.oxfordhealth.com)

Thank you for choosing Oxford Health Plans as the health plan for you and your family.

### IMPORTANT!

In order to process the attached Member Enrollment form and begin coverage, all of the following information must be completed accurately and in its entirety:

**INCOMPLETE FORMS WILL BE RETURNED.**

#### By the Employer

- ✍ Group Number
- ✍ Contract Specific Package (CSP)
- ✍ Billing Group (BG)
- ✍ Date of Full-Time Employment
- ✍ Employer Signature
- ✍ Effective Date of Coverage

#### By the Employee

- ✍ Date of Marriage
- ✍ Date of Birth
- ✍ Social Security Numbers
- ✍ Primary Care Physician selections (Freedom Plan Access, Liberty Plan Access, Freedom Plan Direct and Liberty Plan Direct, no PCP selection is required)
- ✍ Information on other coverage that you or your spouse may have
- ✍ Signature at the bottom of the form
- ✍ Mailing Address, including Zip Code

\* Preexisting condition limitations apply to all Members with gaps in coverage of greater than 63 days in the 12 months prior to the Member's Enrollment Date. Please complete the enclosed "Health Coverage History Form."

**Note: Please press down firmly when completing this form.**

If you have any questions, please feel free to call our Member Service Department at 800-444-6222 or 203-852-1442. Thank you for your cooperation.



A UnitedHealthcare Company

# New York Member Enrollment Form - OHI

Mailing Address: P.O. Box 7085, Bridgeport, CT 06601 • www.oxfordhealth.com

Please do not write in this area, for Oxford use only.

To Be Completed By EMPLOYER				(Please Print)
NAME OF GROUP (EMPLOYER)		GROUP NUMBER	CONTRACT SPECIFIC PACKAGE (CSP)	BILLING GROUP (BG)
EMPLOYEE'S EFFECTIVE DATE OF COVERAGE MO. DAY YEAR		IS INDIVIDUAL COVERED UNDER COBRA? IF YES, QUALIFYING EVENT <input type="checkbox"/> YES <input type="checkbox"/> NO		DATE OF QUALIFYING EVENT MO. DAY YEAR
DATE OF FULL-TIME EMPLOYMENT MO. DAY YEAR		AVERAGE NO. OF HOURS WORKED PER WEEK	EMPLOYEE OCCUPATION: <input type="checkbox"/> EXECUTIVE <input type="checkbox"/> MANAGEMENT <input type="checkbox"/> NON-MANAGEMENT <input type="checkbox"/> HOURLY <input type="checkbox"/> OTHER (PLEASE SPECIFY)	EMPLOYEE CLASSIFICATION <input type="checkbox"/> UNION <input type="checkbox"/> NON-UNION
X EMPLOYER SIGNATURE				DATE

To Be Completed By EMPLOYEE				(Please Print)
SOCIAL SECURITY NO.		LAST NAME		
FIRST NAME	MI	BIRTH DATE MO. DAY YEAR	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	HOME PHONE ( )
STREET ADDRESS		APT. NO.	CITY	BUSINESS PHONE ( )
WILL YOU HAVE ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, CARRIER NAME		NAME OF POLICY HOLDER		POLICY START DATE / /
OXFORD CODE OF PRIMARY CARE PHYSICIAN SELECTED		ARE YOU AN EXISTING PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	PRIOR HEALTH INSURANCE INFORMATION: CARRIER NAME	
OXFORD CODE OF OB/GYN SELECTED (Female Members)		ARE YOU AN EXISTING PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	COVERAGE BEGIN DATE / /	COVERAGE END DATE / /

EMPLOYEE'S Dependent Information				(Please Print)
SPOUSE'S SOCIAL SECURITY NUMBER		SPOUSE'S LAST NAME		SPOUSE'S FIRST NAME MI
SPOUSE'S BIRTH DATE MO. DAY YEAR		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF MARRIAGE MO. DAY YEAR	SPOUSE'S EMPLOYER
WILL YOU HAVE ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, CARRIER NAME		NAME OF POLICY HOLDER		POLICY START DATE / /
OXFORD CODE OF PRIMARY CARE PHYSICIAN SELECTED		ARE YOU AN EXISTING PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	PRIOR HEALTH INSURANCE INFORMATION: CARRIER NAME	
OXFORD CODE OF OB/GYN SELECTED (Female Members)		ARE YOU AN EXISTING PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	COVERAGE BEGIN DATE / /	COVERAGE END DATE / /
ELIGIBLE CHILD'S SOCIAL SECURITY NO.		ELIGIBLE CHILD'S LAST NAME		ELIGIBLE CHILD'S FIRST NAME MI <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
ELIGIBLE CHILD'S BIRTH DATE MO. DAY YEAR		IS THIS DEPENDENT DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO	WILL YOU HAVE ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD? <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, CARRIER NAME:	NAME OF POLICY HOLDER
OXFORD CODE OF PRIMARY CARE PHYSICIAN SELECTED		ARE YOU AN EXISTING PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	PRIOR HEALTH INSURANCE INFORMATION: CARRIER NAME	
OXFORD CODE OF OB/GYN SELECTED (Female Members)		ARE YOU AN EXISTING PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	COVERAGE BEGIN DATE / /	COVERAGE END DATE / /
ELIGIBLE CHILD'S SOCIAL SECURITY NO.		ELIGIBLE CHILD'S LAST NAME		ELIGIBLE CHILD'S FIRST NAME MI <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
ELIGIBLE CHILD'S BIRTH DATE MO. DAY YEAR		IS THIS DEPENDENT DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO	WILL YOU HAVE ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD? <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, CARRIER NAME:	NAME OF POLICY HOLDER
OXFORD CODE OF PRIMARY CARE PHYSICIAN SELECTED		ARE YOU AN EXISTING PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	PRIOR HEALTH INSURANCE INFORMATION: CARRIER NAME	
OXFORD CODE OF OB/GYN SELECTED (Female Members)		ARE YOU AN EXISTING PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	COVERAGE BEGIN DATE / /	COVERAGE END DATE / /
ELIGIBLE CHILD'S SOCIAL SECURITY NO.		ELIGIBLE CHILD'S LAST NAME		ELIGIBLE CHILD'S FIRST NAME MI <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
ELIGIBLE CHILD'S BIRTH DATE MO. DAY YEAR		IS THIS DEPENDENT DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO	WILL YOU HAVE ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD? <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, CARRIER NAME:	NAME OF POLICY HOLDER
OXFORD CODE OF PRIMARY CARE PHYSICIAN SELECTED		ARE YOU AN EXISTING PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	PRIOR HEALTH INSURANCE INFORMATION: CARRIER NAME	
OXFORD CODE OF OB/GYN SELECTED (Female Members)		ARE YOU AN EXISTING PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	COVERAGE BEGIN DATE / /	COVERAGE END DATE / /
ELIGIBLE CHILD'S SOCIAL SECURITY NO.		ELIGIBLE CHILD'S LAST NAME		ELIGIBLE CHILD'S FIRST NAME MI <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
ELIGIBLE CHILD'S BIRTH DATE MO. DAY YEAR		IS THIS DEPENDENT DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO	WILL YOU HAVE ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD? <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, CARRIER NAME:	NAME OF POLICY HOLDER
OXFORD CODE OF PRIMARY CARE PHYSICIAN SELECTED		ARE YOU AN EXISTING PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	PRIOR HEALTH INSURANCE INFORMATION: CARRIER NAME	
OXFORD CODE OF OB/GYN SELECTED (Female Members)		ARE YOU AN EXISTING PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	COVERAGE BEGIN DATE / /	COVERAGE END DATE / /

If you have additional dependents, please use another enrollment form to provide the necessary information. In order to help us quickly process this form and avoid delays, please make sure all areas are properly filled out.

I understand that my enrollments and benefits are in accordance with those described in the Oxford Health Insurance Certificate. I understand that, in order to receive in-network benefits, I and any enrolled dependents must seek care through our Oxford affiliated primary care physician or through an Oxford-affiliated specialist physician with an authorized referral from the primary care physician if required. I further understand that if I do not adhere to these requirements, I will be eligible only for out-of-network health insurance coverage under the terms of the Certificate.

Any person who knowingly and with 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	EMPLOYEE/APPLICANT SIGNATURE	DATE
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