Oxford Health Plans®

Freedom Plan® Direct℠

Pennsylvania Small Group Application

Oxford Health Insurance, Inc.

Mailing Address: 14 Central Park Drive Hooksett, NH 03106 • www.oxfordhealth.com

I. GENERAL INFORMATION

1. Full legal name of company:

2. Address of company:
(Street Address
City, State, Zip Code)
Please do not use a P.O. Box

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: Extension:

d. Fax Number:

e. E-mail address:

4. Name and title of person to receive correspondence/billing statements (if different from above):

a. Name:

b. Title:

c. Address:
(Street Address
City, State, Zip Code)

d. Phone Number: Extension:

e. Fax Number:

f. E-mail address:

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

6. Start date of business:
MM DD YY

7. Full legal name and address of parent company:
a. Name:
b. Address:

Name of Company: ____

8. Nature of business: | | | | | | | | | | | | | | | | | | | |

9. SIC Code: | | | | | | | | | | | | | | | | | | | |

10. Type of Organization: ❑ **Corporation** ❑ **Partnership** ❑ **Proprietorship** ❑ **LLC** ❑ **Other**______________________

11. Tax identification code or number:

a. Federal I.D. ____

12. Did your group employ at least 2 but no more than 50 employees for at least 50% of your business days during the preceding 12 months?

❒ **Yes** ❒ **No**

II. ADMINISTRATIVE INFORMATION

The term "coverage" refers to the benefits provided by Oxford, pursuant to the Group Certificate.

1. **Effective date:** We request that this coverage be effective ______________________________.
   (Month/Day/Year)

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

3. **Open enrollment period:** The open enrollment period will be the month prior to your anniversary date. The open enrollment effective date will be the first of the month following the period.

4. **Employee Eligibility:** 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.

   a. *Full-time Employees:* All permanent, full-time employees who work at least ______ hours per week, including business owners and principals. (minimum 20 hours/week).

   b. *Retired Employees:* ❑ Covered ❑ Not Covered

   The definition of a Retired Employee is:

   ❑ an employee who is retired and on pension by the employer.

   ❑ an employee who is retired and 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.

   Are any classes excluded? ❑ Yes ❑ No

   If yes, indicate classes excluded: ____

5. **Number of Employees Eligible on Effective Date:** Full-time Employees _____ Part-time Employees _____ Retired Employees _____
   How many employees will enroll with Oxford Health Plans? ____________

6. **Employee Contributions**
   Toward Employee Premium: ____%
   Toward Family Premium: ____%
   (employee contribution cannot exceed 50%)

7. **Number of Employees** enrolling with Oxford Health Plans with the new group application __________

8. **Number of waivers for health coverage submitted** ____________

Name of Company: ____________________

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 ____________________

____

a) Waiting period____ days/months from date of hire

❑ **i) Eligibility**

On the date the employee completes the waiting period

Termination

Date of termination of employment

❑ **ii) Eligibility**

First of the month after the employee completes the waiting period

Termination

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

b) Should the waiting period be waived for rehires?

❑ **Yes** ❑ **No**

If rehired within ___ month(s)

CLASS II

Definition of Class II ____________________

____

a) Waiting period____ days/months from date of hire

❑ **i) Eligibility**

On the date the employee completes the waiting period

Termination

Date of termination of employment

❑ **ii) Eligibility**

First of the month after the employee completes the waiting period

Termination

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

b) Should the waiting period be waived for rehires?

❑ **Yes** ❑ **No**

If rehired within ___ month(s)

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

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

10. Continuation of Coverage:

a. Are there any employees or dependents of employees who are covered under COBRA on your current plan?

❑ Yes ❑ No If Yes, identify the number of individuals ____________

b. Are there any employees or 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? ______

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

12. 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.

13. 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.

Name of Company: ____

III. PRODUCT/PLAN DESIGN

1. Please select a Freedom Plan Direct option:

In-Network/Out-of-Network*

Options	❑ Plan A	❑ Plan B	❑ Plan C	❑ Plan D	❑ Plan E	❑ Plan F	❑ Plan G
Copayment	N/A	N/A	N/A	N/A	N/A	N/A	$25
Single Deductible	$1,000/ $1,000	$1,000/ $1,000	$2,000/ $2,000	$2,000/ $2,000	$3,000/ $3,000	$5,000/ $5,000	$1,000/ $1,000/
Coinsurance	90%/70%	80%/60%	90%/70%	80%/60%	80%/60%	80%/60%	90%/70%
Coinsurance Limit	$10,000	$10,000	$10,000	$10,000	$20,000	$20,000	$10,000
Single Maximum Out-of-Pocket	$2,000/ $4,000	$3,000/ $5,000	$3,000/ $5,000	$4,000/ $6,000	$7,000/ $11,000	$9,000/ $13,000	$2,000/ $4,000

Options	❑ Plan H	❑ Plan I	❑ Plan J	❑ Plan K	❑ Plan L	❑ Plan M	❑ Plan N
Copayment	$25	$25	$25	$25	$25	$25	$25
Single Deductible	$1,000/ $1,000/	$2,000/ $2,000	$2,000/ $2,000	$3,000/ $3,000	$5,000/ $5,000	$500/ $1,000	$500/ $1,000
Coinsurance	80%/60%	90%/70%	80%/60%	80%/60%	80%/60%	80%/60%	90%/70%
Coinsurance Limit	$10,000	$10,000	$10,000	$20,000	$20,000	$10,000	$10,000
Single Maximum Out-of-Pocket	$2,000/ $4,000	$3,000/ $5,000	$4,000/ $6,000	$7,000/ $11,000	$9,000/ $13,000	$2,500 $5,000	$1,500/ $4,000

Other ______________________ (Subject to Home Office Approval)

***Family deductible and out-of-pocket expenses are two times the single amount**

2. Additional Benefit Options:

❑ Vision ❑ Emergency Room Copayment ____ $100 ____ $150

Dependent Student Eligibility Cut-off:
❑ Reaching the age of: 23 (standard) ❑ 25 (non-standard, additional cost)

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

Please select optional prescription drug coverage:

(Deductible is waived for generic drugs)

Options	Generic	Preferred Brand	Brand	Mail Order	Deductible
❑ Plan 1	$15 copayment	50%	50%	N/A	❑ $0 ❑ $50 ❑ $100 ❑ $150 ❑ $250
❑ Plan 2	$10 copayment	$25	$50	$30/$75/$150	$50
❑ Plan 3	Waived Coverage (WC)	WC	WC	WC	WC

Contraceptives: ❑ Yes ❑ No

Name of Company: ____________________

IV. BROKER/AGENT INFORMATION

Broker

1. Full legal name of firm: ____________________

2. Address of company: ____________________

3. Contact: ____________________

4. Telephone/Fax Number: ____________________

5. Social Security # or Fed. Tax ID #: ____________________

6. Broker and/or Agent ID: ____________________

7. Account Executive: __________ Field Office: __________ Phone Number: __________

General Agent

1. Full legal name of firm: ____________________

2. Address of firm: ____________________

V. 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 Applicant

____

Signature of Authorized Officer of Applicant | Title of Officer of Applicant | Date

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 acknowledges that the Effective Date of Coverage is not guaranteed and is subject to receipt by Oxford of full requirements including completed Medical Questionnaires for all employees and their dependents enrolling for coverage. The Applicant hereby confirm 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.

The above named company confirms that we employ no more than 50 full-time non-union employees and no fewer than 2 full-time non-union employees. I understand that 1099-compensated individuals are not eligible for group coverage with Oxford Health Insurance. 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 subjects such person 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 | Duly Licensed Resident Agent/Broker