



Name of Company: \_\_\_\_\_

8. Nature of business:

Grid for business nature description

9. SIC Code:

\_\_\_\_\_

10. Tax identification Code or Number:

a. Federal I.D.

\_\_\_\_\_

b. State Tax I.D.

\_\_\_\_\_

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 health coverage which is still in force or that has terminated within the past three (3) years.

Table with 4 columns: Type of coverage, Name of carrier, Effective date, If terminated, date terminated

4. Employee 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 20 hours per 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.

Name of Company: \_\_\_\_\_

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**

**Waiting Period (Please enter zero for no waiting period)**

- \* \_\_\_\_\_ month(s) of continuous service, or
- \* \_\_\_\_\_ days of continuous service.

**\*6 month maximum**

**Effective Date of Coverage (Please select one)**

- Date on which the employee completes the waiting period.
- On the first day of the calendar month coinciding with completion of the waiting period. (i.e., the employee will complete the waiting period on 2/15 and will therefore, be eligible to enroll on 2/1).
- On the first day of the month following the date on which the employee completes the waiting period. (i.e., the employee will complete the waiting period on 2/15 and will therefore, be eligible to enroll on 3/1).

**ii) Termination**

- Date of termination of employment.
- On the last day of the calendar month in which employee's employment terminates.

**iii) Waiting Period for Rehires**

Waiting Period Waived for Rehires?  Yes  No  
**If yes, waived if rehired within \_\_\_\_\_ month(s).**

**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**

**Waiting Period (Please enter zero for no waiting period)**

- \* \_\_\_\_\_ month(s) of continuous service, or
- \* \_\_\_\_\_ days of continuous service.

**\*6 month maximum**

**Effective Date of Coverage (Please select one)**

- Date on which the employee completes the waiting period.
- On the first day of the calendar month coinciding with completion of the waiting period. (i.e., the employee will complete the waiting period on 2/15 and will therefore, be eligible to enroll on 2/1).
- On the first day of the month following the date on which the employee completes the waiting period. (i.e., the employee will complete the waiting period on 2/15 and will therefore, be eligible to enroll on 3/1).

**ii) Termination**

- Date of termination of employment.
- On the last day of the calendar month in which employee's employment terminates.

**iii) Waiting Period for Rehires**

Waiting Period Waived for Rehires?  Yes  No  
**If yes, waived if rehired within \_\_\_\_\_ month(s).**

**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.

**9. Dependent Eligibility:** Dependents are defined as follows: • a legal spouse; and • any child who has not reached age 19 or 24, and who is not married; and who is chiefly dependent upon the employee for support.

The term "child" means the employee's children, including any legal stepchild, legally or proposed adoptive child who is physically placed in subscribers home, or child for whom the employee or employee's spouse is the court appointed legal guardian.

If a child is a registered full-time student at a university, college, or similar institution of higher learning, then that child will be covered until the earlier of:  
• the date on which he/she is no longer a registered full-time student:  
• the date he/she reaches age:  23  24 or  25 (**Non-standard, additional cost**) (check one)

Name of Company: \_\_\_\_\_

If a child cannot support him/herself due to mental retardation 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:** Please refer to your Group Certificate for a complete list of exclusions and limitations.

## III. PRODUCT / PLAN DESIGN

### Section 1: PLAN OPTIONS

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

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

- |  |  |
|--|--|
| <input type="checkbox"/> Liberty Schoolboard/Municipality Traditional Plan | <input type="checkbox"/> Freedom Schoolboard/Municipality Traditional Plan |
| <input type="checkbox"/> Liberty Schoolboard/Municipality Access Plan      | <input type="checkbox"/> Freedom Schoolboard/Municipality Access Plan      |
| <input type="checkbox"/> Liberty Schoolboard/Municipality Classic Plan     | <input type="checkbox"/> Freedom Schoolboard/Municipality Classic Plan     |
| <input type="checkbox"/> Freedom Plan Classic                              | <input type="checkbox"/> Liberty Plan Classic                              |
| <input type="checkbox"/> Freedom Plan Access                               | <input type="checkbox"/> Liberty Plan Access                               |
| <input type="checkbox"/> Oxford USA (United Choice Plus Network)           |  |

**2. Please complete section below (please mark N/A if not applicable):**

Office Copayment: _____	Deductible: _____
Coinsurance %: _____	Maximum Out-of-Pocket: _____
Family Multiple (2, 2.5, 3): _____	UCR Level: _____

**3. Additional Benefit Information (All information is subject to Home Office approval):**

Prescription Plan :  Yes  No

**Copayment Information:**

Deductible: _____	Generic: _____
Preferred Brand: _____	Non-preferred Brand _____

Mail-Order Prescription Drug Plan:  Yes  No  
(if applicable) Oral Contraceptives:  Yes  No

- |  |  |
|--|--|
| <input type="checkbox"/> Vision Reimbursement: _____                                   | <input type="checkbox"/> 90 Visits Outpatient Physical Therapy |
| <input type="checkbox"/> 30 Visits Outpatient Mental Health                            | <input type="checkbox"/> Unlimited Skilled Nursing Facility    |
| <input type="checkbox"/> Enhanced Chiropractic Services (\$1,000 limit Out-of-Network) | <input type="checkbox"/> Dental Plan Premium                   |
| <input type="checkbox"/> Dental Plan Enhanced  | <input type="checkbox"/> Unlimited Durable Medical Equipment   |
| <input type="checkbox"/> Exercise Facility   | <input type="checkbox"/> Emergency Room Copayment _____        |
| <input type="checkbox"/> Inpatient/Outpatient Hospital Copayment                       |  |

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

Name of Company: \_\_\_\_\_

### III. PRODUCT / PLAN DESIGN (CONTINUED)

## Section 2: FREEDOM PLAN DIRECT AND LIBERTY PLAN DIRECT PLAN DESIGNS

No referrals are required for these plan designs.

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

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

- Freedom Plan Direct (Office Visit Copayment)
- Freedom Plan Direct (Deductible & Coinsurance only)
- Liberty Plan Direct (Office Visit Copayment)
- Liberty Plan Direct (Deductible & Coinsurance only)
- Oxford USA (Office Visit Copayment)
- Oxford USA (Deductible & Coinsurance only)

**2. Please complete section below (if applicable):**

Office Visit Copayment: \_\_\_\_\_

**In-network**

Deductible: \_\_\_\_\_

Coinsurance: \_\_\_\_\_

Coinsurance Maximum: \_\_\_\_\_

**Out-of-network**

Deductible: \_\_\_\_\_

Coinsurance: \_\_\_\_\_

Coinsurance Maximum: \_\_\_\_\_

**3. Additional Benefit Information (All information is subject to Home Office approval):**

Prescription Drug Plan :  Yes  No

**Copayment Information**

Deductible \_\_\_\_\_

Generic \_\_\_\_\_ Preferred Brand \_\_\_\_\_ Non-preferred Brand \_\_\_\_\_

Mail-Order Prescription Drug Plan:  Yes  No Oral Contraceptives:  Yes  No

- Vision Reimbursement \_\_\_\_\_
- 30 Visits Outpatient Mental Health (Non-biological)
- Enhanced Chiropractic Services (\$1,000 Limit Out-of-Network)
- Emergency Room Copayment \_\_\_\_\_
- 90 Visits Outpatient Physical Therapy
- Skilled Nursing Facility  Unlimited  100 days per calendar year
- Domestic Partner
- Unlimited Durable Medical Equipment
- Other (Subject to Home Office Approval): \_\_\_\_\_

Name of Company: \_\_\_\_\_

### III. PRODUCT / PLAN DESIGN (CONTINUED)

#### Section 3: Oxford MyPlan Options

**Note:** Groups enrolling in Oxford MyPlan must also fill out an Oxford MyPlan Health Reserve Account Application (form #6740).

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

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

**Please Select Network:**  Freedom  Liberty

Oxford MyPlan (Office Visit Copayment)       Oxford MyPlan (Deductible & Coinsurance only)

**Please Note:** No referrals are required for these plan designs.

**2. Please complete section below (please mark N/A if not applicable):**

Office Visit Copayment: \_\_\_\_\_  None (Deductible & Coinsurance only)

**In-network**

Deductible: \_\_\_\_\_

Coinsurance: \_\_\_\_\_

Coinsurance Maximum: \_\_\_\_\_

**Out-of-network**

Deductible: \_\_\_\_\_

Coinsurance: \_\_\_\_\_

Coinsurance Maximum: \_\_\_\_\_

**Please Note:** Family deductible and out-of-pocket expenses are two times the single amount.

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

**3. Additional Benefit Information (All information is subject to Home Office approval):**

Prescription Drug Plan :  Yes  No

**Copayment Information**

Deductible: \_\_\_\_\_

Generic: \_\_\_\_\_ Preferred Brand: \_\_\_\_\_ Non-preferred Brand: \_\_\_\_\_

Mail-Order Prescription Drug Plan:  Yes  No      Oral Contraceptives:  Yes  No

Vision Reimbursement \_\_\_\_\_

Name of Company: \_\_\_\_\_

### III. PRODUCT / PLAN DESIGN (CONTINUED)

#### Section 4: Oxford HSA Direct Options

No referrals are required for these plan designs.

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

1. Please select network:

- Freedom       Liberty       Oxford USA (First Health Network)

2. Please complete section below:

**In-network** \*\*

Deductible: \_\_\_\_\_

Coinsurance: \_\_\_\_\_

Coinsurance Maximum: \_\_\_\_\_

**Out-of-network**

Deductible: \_\_\_\_\_

Coinsurance: \_\_\_\_\_

Coinsurance Maximum: \_\_\_\_\_

**Prescription Drug Plan** (Required) \*\*

Copayment Information

Generic \_\_\_\_\_ Preferred Brand \_\_\_\_\_ Non-preferred Brand \_\_\_\_\_

Mail-Order Prescription Drug Plan:  Yes  No      Oral Contraceptives:  Yes  No

3. Additional Benefit Information (All information is subject to Home Office approval):

- Vision Reimbursement \_\_\_\_\_
- 30 Visits Outpatient Mental Health (Non-biological)
- Enhanced Chiropractic Services (\$1,000 Limit Out-of-Network)
- Unlimited Durable Medical Equipment
- 90 Visits Outpatient Physical Therapy
- Skilled Nursing Facility     Unlimited     100 days per calendar year
- Domestic Partner
- Other (Subject to Home Office Approval): \_\_\_\_\_

**\*\*NOTE:** As of April 1, 2005, 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.

Name of Company: \_\_\_\_\_

### 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

X

Signature of Authorized Officer of Company

Title of Officer of Company

Date

### V. COBRA AND EXTENSION OF BENEFITS

- 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.

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 (full legal Name)

X

Signature of Authorized Officer of the Applicant

Title of Officer of Applicant

X

Witness

Duly Licensed Resident Agent/Broker