

15. **Deposit** \$ _____ **Premium Paid:** Monthly Quarterly

Premium will be due as of the effective date. The premium for the first month of coverage must be attached.

Affiliates, subsidiaries or branches (must be included for purposes of participation).

Legal name and location	Number of eligible employees in this company	Number of eligible employees to be insured

II. SPECIFICATIONS FOR COVERAGE

HEALTH BENEFITS

Product: HMO HMO Select

Network: Liberty Freedom

PLAN OPTIONS

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	<input type="checkbox"/> Plan 11
Copayment	\$15	\$20	\$30	\$15/\$30	\$30/\$50	\$15/\$30	\$25/\$40	\$30/\$50	\$30	\$30	\$30/\$50
Deductible	N/A	N/A	N/A	N/A	N/A	\$500	\$1,000	\$2,000	\$500	\$1,000	\$1,000
Coinsurance	100%	100%	100%	100%	100%	90%	80%	70%	90%	80%	80%
MOOP	N/A	N/A	N/A	N/A	N/A	\$1,500	\$3,000	\$5,000	\$1,500	\$3,000	\$3,000

* Not available with HMO Select

PRESCRIPTION DRUG BENEFITS

Copayment Information: Standard (Plan Copayment)

Optional Riders (Generic/Preferred Brand/Brand Copayment) \$5/\$15/\$50* \$7/\$20/\$50* \$7/\$15/\$25 \$7/\$15/\$35*
 \$10/\$25/\$50* \$15/50%*

*Pharmacy Deductible (Waived for generic drugs): None \$50 \$100

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

OPTIONS

- Vision Care Rider
- Enhanced Dental Rider
- Premium Dental Rider
- Physician visits for preventive care at no charge
- Hospital Confinement Rider (Plans 1-5)
- Hospital Confinement Rider (Plans 6-8)
- Domestic Partner

III. ALL QUESTIONS MUST BE ANSWERED

- Is there any Group Health Plan:
 Now in force and to be continued? Yes No
 Currently being applied for? Yes No
 If "yes", identify the name of the Group Health Plan, give a description of the plan(s) and the name of insurance carrier(s):

- Name of present or prior group carrier:
 Effective date of prior coverage: _____ Cancellation/termination date: _____
 Is the coverage applied for in this application replacing other group insurance? Yes No
 If "yes", give reason: _____
 Plan being replaced: A B C D E HMO HMO-POS Dual-Contract POS
 Other: _____

III. ALL QUESTIONS MUST BE ANSWERED (CON'T)

3. Has your firm been uninsured for three or more months prior to application? Yes No
4. What forms of insurance are now or were in force?
 Health Benefits Prescription Drugs (Attach copies of Booklet/Certificate of Coverage and most recent Billing Statement)
5. Are extended benefits provided in case of termination of health benefits? Yes No
6. To the best of your knowledge are there any current or former employees or their eligible dependents whose health insurance is being continued?
 Yes No

Please provide the following information for each current/former employee or dependent on health continuations.

Name of Employee/ Dependent	Date of Birth	Type of Continuation State/ Federal/Extended Benefits	Reason for Termination Disability/Other	Continuation Dates	
				Start	End

If additional space is needed, attach a separate sheet, signed and dated.

7. To the best of your knowledge:
- A. Are any employees or dependents presently incapacitated? Yes No
- B. Are any dependent children incapable of self-support due to a physical or mental disability? Yes No

Additional space to explain if Items 1, 2 or 3 were answered "yes". Refer to the question number, and give details including names, where appropriate.

8. Does the employer participate in an arrangement with a Professional Employer Organization? Yes No
 (Refer to Advisory Bulletin 00-SEH-02 if you need information concerning what constitutes a Professional Employer Organization.)

IV. AGENT/PRODUCER INFORMATION

Broker: _____
Name Code Address

Broker: _____
Name Code Address

V. SIGNATURE

A full-time employee is one who regularly works at least 25 hours per week at his or her employer's place of business. It is further understood that no agent has power on behalf of Oxford Health Plans (NJ), Inc. to make or modify any request or application for insurance or to bind Oxford Health Plans (NJ), Inc. by making any promise or representation or by giving or receiving any information. It is further understood that no insurance will be effective unless and until the application is accepted in writing by Oxford Health Plans (NJ), Inc. Final rates will be based on enrollment data as of the Policy effective date. No contract of insurance is to be implied in any way on the basis of the completion and/or submission of this application.

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: _____ on _____

 Print name of Officer, Partner or Proprietor

 Signature of Officer, Partner or Proprietor

 Witness to Signature

Note: If there are any modifications to the statements and answers given in this application (i.e., crossed out, whited-out, erased information), the applicant must attest to the modifications by giving a complete signature in the margin near the modification.

