



A UnitedHealthcare Company

CT Blue Ribbon
Freedom Plan®
Freedom Plan® SelectSM
HMO/Freedom
HMO Select

HMO LaurelSM
HMO Laurel SelectSM
Freedom Plan® LaurelSM
Freedom Plan® Laurel SelectSM

Connecticut Small Group Application-OHP

Oxford Health Plans (CT), Inc.

Corporate Address: 48 Monroe Turnpike, Trumbull, CT 06611

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 PO Box.)

3. Plan Administrator/Contact:

a. Name and Title:

b. Address:

(If different from address of company)

c. Phone Number:

d. Fax Number:

Area Code

Area Code

e. E-mail Address:

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

a. Name:

b. Title:

c. Address:

(Street Address
City, State, Zip Code)

d. Phone Number:

e. Fax Number:

Area Code

Area Code

5. Start Date of Business:

6. Full legal name and address of parent company:

a. Name:

b. Address:

7. Full legal name & address of each subsidiary and/or affiliated company,

branch or satellite office whose
employees are to be covered:

Defining Eligible Employees (continued)

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.

b) **Eligibility & Termination:** The employee will become eligible on the latter of the effective date of this plan or the date selected below

*Indicate number of months or days, whichever is applicable, in the space provided below. In (i) below, if there is no waiting period, insert "0" in the space provided for the number of days or months of continuous service. In (ii) below, indicate whether eligibility is first day of the calendar month coinciding with or next following the date on which the employee completes the group specified length of continuous service.

CLASS I

Definition of Class I _____

i) Eligibility

- Date on which the employee completes:
* _____ month(s) of continuous service, or
* _____ days of continuous service.

Termination

- Date of termination of employment

ii) Eligibility

- On the first day of the calendar month coinciding with or next following the date on which the employee completes:
* _____ month(s) of continuous service, or
* _____ days of continuous service.

Termination

- 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 _____ months.

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

- Date on which the employee completes:
* _____ month(s) of continuous service, or
* _____ days of continuous service.

Termination

- Date of termination of employment

ii) Eligibility

- On the first day of the calendar month coinciding with or next following the date on which the employee completes:
* _____ month(s) of continuous service, or
* _____ days of continuous service.

Termination

- 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 _____ months.

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 Total Employees the Effective Date:

Full-time Employees _____ Part-time Employees _____ Retired Employees _____

Of the Total employees: How many are active eligible full-time employees who work in CT? _____

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. Health Benefits covered by Medicare Part A, Part B and Part D are carved out 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 the limiting age; and
 - who is not married; and
 - who is chiefly dependent upon the employee for support.

The term "child" refers to 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:

- no longer being a registered full-time student;
- reaching the age of: 23 (standard) or 25 (non-standard, additional cost) **(select one)**

If a child cannot support him/herself due to mental 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: CT Blue Ribbon, Freedom Plan, Freedom Plan Select, HMO and HMO Select

1. Please select a plan type and a plan number (if applicable):

CT Blue Ribbon Plan Design

1. Office copayment	\$10
2. Inpatient Facility copayment	\$500 Per Admission not to exceed 50% of the charge for the services provided
3. Skilled Nursing Facility copayment	\$500 Per Admission not to exceed 50% of the charge for the services provided
4. Emergency Room copayment	\$25
5. Durable Medical Equipment copayment	\$400 Per Item
6. Prosthesis copayment	\$400 Per Item, waived for internal prosthesis
7. Physical Therapy limit	30 Visits per prescribed course of treatment
8. Pharmacy (includes Contraceptives)	
a. Generic/Brand copayment	\$5
b. Limit	\$1,000
9. Dependent age cutoff	19/23
10. Out-of-pocket for covered services	\$1,500 single / \$3,000 family

Please Note: If CT Blue Ribbon Plan Design was selected, the following options are not available.

SECTION 2: HMO Laurel, HMO Laurel Select, Freedom Plan Laurel, Freedom Plan and Laurel Select

1. Please select a plan type and a plan design:

HMO Laurel

HMO Laurel Select

(Deductibles and Out-of-Pocket Accumulation Periods are on a Calendar Year basis.)

Options:	<input type="checkbox"/> A.	<input type="checkbox"/> E.	<input type="checkbox"/> F.
Plan Type:	HMO	HMO	HMO
Office Copayment (PCP/Specialist):	\$30/\$45	\$15/\$25	\$25/\$40
Single/Family Deductible:	N/A	N/A	N/A
Coinsurance:	N/A	N/A	N/A
Hospital Copayment: (up to \$2,000/calendar year)	\$500/day	\$100/continuous confinement	\$250/day
Outpatient Surgery Copayment:	\$250	\$50	\$100
Emergency Room Copayment:	\$150	\$75	\$100

For prescription and additional riders please see the following page.

Freedom Plan Laurel

Freedom Plan Laurel Select

(Deductibles and Out-of-pocket Accumulation Periods are on a Calendar Year basis.)

Options:	<input type="checkbox"/> B.	<input type="checkbox"/> C.	<input type="checkbox"/> D.
Plan Type:	POS	POS	POS
Office Copayment (PCP/Specialist):	\$15/\$25	\$25/\$40	\$30/\$45
Out-of-network Deductibles:			
Single:	\$1,000	\$1,000	\$2,500
Family:	\$3,000	\$3,000	\$7,500
Out-of-network Coinsurance:	70%	70%	70%
Single Coinsurance Maximum:	\$10,000	\$15,000	\$20,000
In-network Hospital Copayment:	\$100 per admission (up to \$2,000 per calendar year)	\$250 per day (up to \$2,000 per calendar year)	\$500 per day (up to \$2,000 per calendar year)
Outpatient Surgery Copayment:	\$50	\$100	\$250
Emergency Room Copayment:	\$75	\$100	\$150

For prescription and additional riders please see the following page.

Section 2: HMO Laurel, HMO Laurel Select, Freedom Plan Laurel, Freedom Plan Laurel Select (con't)

2. Please select a Prescription rider and desired coverages:

Pharmacy benefit: (Generic/ Preferred Brand/ Non-preferred Brand Copayment)

- \$10/\$20/\$40 50% (excludes mail order) \$15/50%
 None

Deductible options (Deductible is waived for generic drugs)

- None \$50

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

3. Additional Benefit Information

- Vision
 Dental Plan Premium Dental Plan Enhanced
Outpatient Physical Therapy 60 Visits 90 Visits (Standard)
Skilled Nursing Facility 30 Visits (Standard) Unlimited
 Other: _____

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 Applicant

Signature of Authorized Officer of Applicant

Title of Officer of Applicant

Date

V. COBRA & EXTENSION OF BENEFITS DATA

1. Are there any employees or dependents of employees who are covered under COBRA or State Continuation on your current plan? Yes No

If yes, identify the number of individuals _____

2. 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? _____

VI. BROKER / AGENT INFORMATION

	Broker	Co-Broker	General Agent
1. Name of Broker/Agent :			
2. Oxford Broker Code (Required):			
3. Social Security # or Federal Tax ID #:			
4. Broker Street Address:			
5. City, State, Zipcode:			
6. Telephone Number:			
7. Fax Number:			
8. E-mail Address:			
9. Commission Split %:			
10. Oxford 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. In general, our total bonuses are less than 10% of total producer compensation paid. 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. For specific information about the compensation payable with respect to your particular policy, please contact your producer.

VII. 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 Family Health Statements for all employees and their dependents enrolling for coverage. 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.

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 (Correct Legal Name)

X

Signature of Authorized Officer of the Applicant

X

Title of Officer of Applicant

X

Witness

Duly Licensed and Appointed Producer*

***Please note: If you are not currently appointed by Oxford in CT, you must contact Oxford's Commissions Department at 1-888-666-6844 in advance of executing this application.**