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# New York Community-Rated Small Group Application - OHP

Oxford Health Plans (NY), Inc. • Oxford Health Insurance Inc. • www.oxfordhealth.com

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

## I. GENERAL INFORMATION

1. Full Legal Name of Group: [Grid]

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

3. Plan Administrator/Contact:  
a. Name [Grid]  
b. Title [Grid]  
c. Address (If different from primary) [Grid]  
City, State, Zipcode [Grid]  
d. Phone Number [Grid] Ext. [Grid]  
e. Fax Number [Grid]  
f. E-mail Address [Grid]  
g. Add'l Contact Name/ Address [Grid]

4. Name and title of person to receive billing statements:  
a. Name [Grid]  
b. Title [Grid]  
c. Address (If different from primary) [Grid]  
City, State, Zipcode [Grid]  
d. Phone Number [Grid] Ext. [Grid]  
e. Fax Number [Grid]

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

6. Nature of Business: [Grid]

7. SIC Code: [Grid]

8. Tax Identification Number: [Grid]

## 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: \_\_\_\_\_.
2. **Anniversary date:** The anniversary date is the first day of the calendar month that is closest to the effective date.
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:** \_\_\_\_\_ / **Number of Temporary/Contracted Workers:** \_\_\_\_\_
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 Health Plans 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. **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.

*Eligibility and 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 rehire?**

Yes  No

(If yes, rehired within \_\_\_\_\_ month).

### 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 rehire?**

Yes  No

(If yes, rehired within \_\_\_\_\_ month).

\*If you wish to add a second class, based on plan design, please indicate which class should receive which plan design in the tables on the following page.

# III. PRODUCT / PLAN DESIGN

1. Please put a check mark in the appropriate plan box in the tables below for which plan design option you wish to have available to your employees.

## 80% Coinsurance Plans

Single Deductible		\$200	\$200	\$250	\$250	\$300	\$300	\$500	\$500	\$750	\$750
Coinsurance Limit		\$5,000	\$10,000	\$5,000	\$10,000	\$5,000	\$10,000	\$5,000	\$10,000	\$5,000	\$10,000
<b>Freedom Plan®</b>	Copayment \$ 5										
	\$10										
	\$15										
	\$20										
<b>Liberty Plan<sup>sm</sup></b>	Copayment \$ 5										
	\$10										
	\$15										
	\$20										
<b>Freedom Plan® Select<sup>sm</sup> (Non-Gated)</b>	Copayment \$ 5										
	\$10										

\*\*Liberty Select is not available with an 80% coinsurance.

 Shaded boxes indicate that a particular plan is not available.

## 70% Coinsurance Plans

Single Deductible		\$200	\$200	\$250	\$250	\$300	\$300	\$500	\$500	\$750	\$750	\$750	\$1,000	\$2,000
Coinsurance Limit		\$5,000	\$10,000	\$5,000	\$10,000	\$5,000	\$10,000	\$5,000	\$10,000	\$5,000	\$10,000	\$25,000	\$5,000	\$5,000
<b>Freedom Plan®</b>	Copayment \$ 5													
	\$10													
	\$15													
	\$20													
	*\$25													
<b>Liberty Plan<sup>sm</sup></b>	Copayment \$ 5													
	\$10													
	\$15													
	\$20													
	*\$25													
<b>Freedom Plan® Select<sup>sm</sup> (Non-Gated)</b>	Copayment \$ 5													
	\$10													
	\$15													
	\$20													
<b>Liberty Plan Select<sup>sm</sup> (Non-Gated)</b>	Copayment \$ 5													
	\$10													
	\$15													
	\$20													

\*Plan includes a \$500 Inpatient Hospital Copayment and Standard (70%) UCR level.

 Shaded boxes indicate that a particular plan is not available.

2. Usual and Customary Reimbursement Level:  Standard (70%)  High (80%)  Very High (90%)

3. Pharmacy Benefit:

Options	Generic	Preferred Brand	Non-Preferred Brand	Mail Order	Deductible** (Please select one)
<input type="checkbox"/> Option 1	\$7 copayment	\$20 copayment	\$40 copayment	2x copayment	<input type="checkbox"/> \$0 <input type="checkbox"/> \$50 <input type="checkbox"/> \$100 <input type="checkbox"/> \$250 <input type="checkbox"/> \$500
<input type="checkbox"/> Option 2	\$10 copayment	\$25 copayment	\$50 copayment	2x copayment	<input type="checkbox"/> \$0 <input type="checkbox"/> \$50 <input type="checkbox"/> \$100 <input type="checkbox"/> \$250 <input type="checkbox"/> \$500
<input type="checkbox"/> Option 3	\$15 copayment	50%	50%	2x copayment or 50%	<input type="checkbox"/> \$0 <input type="checkbox"/> \$50 <input type="checkbox"/> \$100 <input type="checkbox"/> \$250 <input type="checkbox"/> \$500
<input type="checkbox"/> Option 4*	\$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 waived for generic 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 retiree's?  Yes  No

4. Other Riders:

- Unlimited Skilled Nursing
- Vision
- Dental Premium
- Dental Enhanced
- Age 25 Dependent Student Cutoff (Age 23 is standard)
- Alternative Medicine
- \$100 Inpatient Hospital Copayment
- \$250 Inpatient Hospital Copayment
- \$500 Inpatient Hospital Copayment
- Mental Health \_\_\_\_\_
- Other \_\_\_\_\_

## 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 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:			
<b>Comments:</b>			

**\*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.

## V I . C O N S E N T

### AUTHORIZATION FOR BROKER TO ACT AS BENEFITS ADMINISTRATOR

The undersigned hereby requests Oxford Health Plans 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 Health Plan 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 Oxford 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.

## V I I . C O B R A & E X T E N S I O N O F B E N E F I T S D A T A

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 selection of benefits 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 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 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 group health coverage 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 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 violation.

**IMPORTANT:** All signature lines below need to be signed and dated.

Oxford Health Plans (NY), Inc.

X

SIGN HERE Signature of Authorized Officer of the Company

Title

X

Witness

**IMPORTANT:** All signature lines below need to be signed and dated.

Oxford Health Insurance, Inc.

X

SIGN HERE Signature of Authorized Officer of the Company

Title

X

Witness