



New Jersey Small Group Transmittal Form

MUST BE filled out by the Broker & Mailed to:

OXFORD HEALTH PLANS, INC.
14 Central Park Drive
HOOKSETT, NH 03106
Att: NJSEH New Group Enrollment

<input type="checkbox"/>	New Group
<input type="checkbox"/>	Correction
<input type="checkbox"/>	Renewal
<input type="checkbox"/>	GUA: _____
<input type="checkbox"/>	Date Complete: _____

Please note below the producer who is to receive the Approval Letter which indicates the Group #.

Effective Date: _____ Group #: _____

Group Name: _____ Brokerage Firm: _____

Address: _____ Address: _____
(cannot use a P.O. Box)

Contact Name: _____ Broker Name: _____

Title: _____ Phone#: _____

Phone #: _____ Fax#: _____

Fax#: _____

PAY COMMISSIONS TO WHO ? In order to be paid commissions, your broker code must be referenced below. If you do not know your code, please contact the Commissions Dept @800-201-4950 x2153 and you can obtain your code over the phone.

Broker Code#: _____	Percentage: _____	% Brokerage Firm: _____
Broker Code#: _____	Percentage: _____	% Brokerage Firm: _____
Broker Code#: _____	Percentage: _____	% Brokerage Firm: _____

Please provide the address info for this producer(s) in the comments section if not referenced above the in the Approval Letter Section.

Prior Carrier: _____ SIC Code: _____

REQUIRED Attachments:

<input type="checkbox"/>	Oxford Transmittal Form	<input type="checkbox"/>	First Month's Premium Attached:
<input type="checkbox"/>	NJ Group Application	<input type="checkbox"/>	Waiver Forms (if applicable)
<input type="checkbox"/>	NJ Certification Form	<input type="checkbox"/>	Student Verification Form (if applicable)
<input type="checkbox"/>	Member Enrollment Form	<input type="checkbox"/>	Copy of Prior Carrier's most recent Bill and/or Benefits Certificate/Booklet
<input type="checkbox"/>	Pre-existing Form	<input type="checkbox"/>	Rate Calculation Quote Sheet including Demographic Adjustment Page

(for groups w/no prior coverage or 2-5 ee's only)

In-Network:

<input type="checkbox"/>	Liberty	<input type="checkbox"/>	Freedom	<input type="checkbox"/>	PPO	<input type="checkbox"/>	POS		
<input type="checkbox"/>	\$5.00	<input type="checkbox"/>	\$10.00	<input type="checkbox"/>	\$15.00	<input type="checkbox"/>	\$20.00	<input type="checkbox"/>	\$30.00
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No						
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No						
<input type="checkbox"/>	100%	<input type="checkbox"/>	90% ***	<input type="checkbox"/>	80% ***				

Must Have

Out-of-Network:

Deductible: \$250 * \$500 \$750 * \$1,000
 Max. Charge Limit: \$5,000 ** \$8,333 ** \$10,000 **
 Coinsurance: ** Plan D (80/20) Plan C (70/30) Plan B (60/40) (Plan B Not Available for Liberty PPO)

* **Deductibles:** \$250 not available w/\$20 copayment, \$750 only avail. w/Plan C & D

** **Max. Charge Limit:** \$10,000 only available w/Plans B, C, and D
 \$5,000 available with Plan C&D, \$8,333 only available with Plan C

*** **In-Network Coinsurance:** 90% only available w/Plan C, 80% only available w/Plan B (Not available for PPO)

Plan B: no Riders are available w/Plan B (no Physical Therapy, Vision, or Dental)

Other Riders:

Physical Therapy: 30 Days (Standard) 90 Days
 Vision: None Yes
 Dental: None Enhanced Premium
 Prescription Drugs: T4,T3,T2,T1* Optional Standard (OV =Rx Copay)

* Mail Order not available on 3 Tier Rx

Eligibility Lag/Waiting Periods:

Present Employee's: None Same as New Hires Other: _____
 New Hires: None Waiting Period: Days Months
(maximum 6 months) (fill in # of days OR months above)

Must pick one of the following waiting periods: the date employee completes waiting period **OR**
 the 1st day of the month following the waiting period

HEALTH RATES:

FINAL RATES are based on Final Enrollment

	<u>Sub-Group 01</u>	<u>Sub-Group 02</u>
Single:	_____	_____
Parent/Children:	_____	_____
Husband/Wife: 0	_____	_____
Family:	_____	_____
Total Monthly Premium:	_____	_____
Number of ee's enrolling:	_____	_____

Please Note: make sure you complete this entire Transmittal form which should match up with the Group Application. Plan changes to increase benefits cannot be made until Renewal.

OTHER PERTINENT INFORMATION/COMMENTS:

ALL INFORMATION MUST BE FILLED IN

SUBMISSION BY:	
Licensed Broker: _____	Date: _____
Signature	
OXFORD SALES REPRESENTATIVE:	