



A UnitedHealthcare Company

Freedom Plan®
Liberty PlanSM
Freedom Plan DirectSM
Liberty Plan DirectSM
Oxford MyPlanSM
Oxford HSA DirectSM

New Jersey Small Group - OHI

Oxford Health Insurance, Inc.

Mailing Address: 14 Central Park Drive, Hooksett, NH 03106 • www.oxfordhealth.com

Please print or type

Policy Number (OHI Use Only): _____

New Policy

Change in Policy

Requested Effective Date: _____

* Note: The effective date will be on or after the date Oxford approves the application.

I. POLICYHOLDER INFORMATION

1. Policyholder (full legal name of company):

Grid for policyholder name

2. Tax Identification Number:

Grid for tax ID number

3. Main Address:

Grid for main address with labels: Street, City, State, Zip Code

Mailing Address:

Grid for mailing address with labels: Street, City, State, Zip Code

Telephone & Facsimile:

Grid for telephone and fax numbers with label: Fax

4. Name of Correspondent:

Grid for correspondent name

5. Type of organization:

Corporation Partnership Proprietorship Other (explain)

6. Nature of business (specify):

_____ SIC Code: _____

7. Number of eligible employees in your company:

Refer to New Jersey Small Employer Certification for the definition of an eligible employee.

8. Number of eligible employees to be insured:

9. Class or classes to be excluded:

10. Insurance Requested For:

Employees Only Employees and Dependents

Should the plan provide coverage for domestic partners as permitted by P.L. 2003, c.246

Yes No

If yes, should the plan provide coverage for children of a covered domestic partner?

Yes No

11. Is the employer subject to the requirements of COBRA?

Yes No

12. Is the employer subject to the requirements of Medicare as a Secondary Payer Rules for eligibility due to age?

Yes No

Due to Disability? Yes No

13. Waiting period before employees become insured: (may not exceed 6 months)

Present employees _____ New or rehired employees _____

14. What percentage of the premium will the employer pay?

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

16. **Other group health or HMO coverage:** Indicate below other group health coverage which is still in force or which terminated within the past three years.

Type of coverage	Name of carrier	Effective date	If terminated, date terminated

II. SPECIFICATIONS FOR COVERAGE

PLEASE SELECT A PLAN FROM SECTION 1, 2 OR 3.

SECTION 1: FREEDOM PLAN & LIBERTY PLAN **PRODUCT** PPO POS **NETWORK** Freedom Liberty

NOTE: Not all plan combinations are available. Please refer to the rate model or your Sales Representative to verify the plan combination you selected is available.

Options	<input type="checkbox"/> Plan C	<input type="checkbox"/> Plan D
Office Copayment	<input type="checkbox"/> \$5 <input type="checkbox"/> \$10 <input type="checkbox"/> \$15 <input type="checkbox"/> \$15/\$25 <input type="checkbox"/> \$20 <input type="checkbox"/> \$25/\$40 <input type="checkbox"/> \$30 <input type="checkbox"/> \$40 <input type="checkbox"/> \$50	<input type="checkbox"/> \$5 <input type="checkbox"/> \$10 <input type="checkbox"/> \$15 <input type="checkbox"/> \$20
In Network Coinsurance	<input type="checkbox"/> 80% <input type="checkbox"/> 90% <input type="checkbox"/> 100%	<input type="checkbox"/> 90% <input type="checkbox"/> 100%
Out Of Network Deductible	<input type="checkbox"/> \$250 <input type="checkbox"/> \$300 <input type="checkbox"/> \$500 <input type="checkbox"/> \$750 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$3,000 <input type="checkbox"/> \$3,500	<input type="checkbox"/> \$200 <input type="checkbox"/> \$250 <input type="checkbox"/> \$300 <input type="checkbox"/> \$500 <input type="checkbox"/> \$750 <input type="checkbox"/> \$1,000
Maximum Out of Pocket	<input type="checkbox"/> \$5,000 <input type="checkbox"/> \$8,333 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$25,000	<input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000

OPTIONS:

- Physician Visits for Preventive Care at no charge
- Hospital Confinement at no charge
- Physical Therapy 90 Rider
- Vision Care Rider
- Enhanced Dental Rider
- Premium Dental Rider
- Domestic Partner

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

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

SECTION 2: Freedom Plan Direct Liberty Plan Direct

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
Copayment	\$15 PCP \$25 Specialist	\$25 PCP \$40 Specialist	\$25 PCP \$40 Specialist	N/A	N/A	N/A
Single * Deductible	\$500/\$1,000	\$500/\$1,000	\$1,000/\$2,000	\$500/\$1,000	\$2,000/\$2,000	\$1,000/\$2,000
Family * Deductible	\$1,000/\$2,000	\$1,000/\$2,000	\$2,000/\$4,000	\$1,000/\$2,000	\$4,000/\$4,000	\$2,000/\$4,000
Coinsurance *	90%/70%	80%/60%	80%/60%	90%/70%	90%/70%	80%/60%
Single Max. * Out-of-Pocket	\$1,500/\$4,000	\$2,500/\$5,000	\$3,000/\$6,000	\$1,500/\$4,000	\$3,000/\$5,000	\$3,000/\$6,000
Family Max. * Out-of-Pocket	\$3,000/\$8,000	\$5,000/\$10,000	\$6,000/\$12,000	\$3,000/\$8,000	\$6,000/\$10,000	\$6,000/\$12,000

*In-Network/Out-of-Network

DIRECT OPTIONS:

- Vision Care Rider Premium Dental Rider
 Enhanced Dental Rider Domestic Partner

PRESCRIPTION DRUG BENEFITS

Copayment Information:

- Standard (Plan Copayment) Available only with office visit Copayment plans

Optional Riders (Generic/Preferred Brand/Brand Copayment)

- \$7/\$15/\$25 \$10/\$25/\$50* \$15/50%* \$5/\$15/\$50* \$7/\$20/\$50* \$7/\$15/\$35*
 *Pharmacy Deductible (Waived for generic drugs): None \$50

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

SECTION 3: OXFORD MyPLAN

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

HEALTH BENEFITS:

- Freedom Network Liberty Network

Options	<input type="checkbox"/> Plan 1	<input type="checkbox"/> Plan 2	<input type="checkbox"/> Plan 3
Copayment	\$25/\$40	N/A	N/A
Single Deductible (In-network/Out-of-network)	\$1,000/\$2,000	\$2,000/\$2,000	\$1,000/\$2,000
Family Deductible (In-network/Out-of-network)	\$2,000/\$4,000	\$4,000/\$4,000	\$2,000/\$4,000
Coinsurance (In-network/Out-of-network)	80%/60%	90%/70%	80%/60%
Single Out of Pocket Maximum (Family = 2x)	\$3,000/\$6,000	\$3,000/\$5,000	\$3,000/\$6,000

OXFORD MYPLAN OPTIONS (ALL INFORMATION IS SUBJECT TO HOME OFFICE APPROVAL)

Vision Domestic Partner

PRESCRIPTION DRUG BENEFITS:

Prescription Drug Plan: Yes No

Copayment Information:

Standard (Plan Copayment) Available only with Plan #1.

Optional Riders Generic/Preferred Brand/Brand Copayment)

\$7/\$15/\$25 \$10/\$25/\$50* \$15/50%*

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

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

SECTION 4: OXFORD HSA DIRECT

Note: Groups enrolling in the Oxford HSA Direct must also fill out an Oxford HSA Banking Notification Form (#7423)

HEALTH BENEFITS: Freedom Network Liberty Network

Options	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
Single Deductible** (In-network/Out-of-network)	\$1,100/\$2,000	\$2,000/\$2,000	\$2,500/\$2,500	\$1,100/\$2,000	\$2,000/\$2,000	\$2,500/\$2,500
Family Deductible** (In-network/Out-of-network)	\$2,200/\$4,000	\$4,000/\$4,000	\$5,000/\$5,000	\$2,200/\$4,000	\$4,000/\$4,000	\$5,000/\$5,000
Coinsurance (In-network/Out-of-network)	80%/60%	90%/70%	90%/70%	100%/70%	100%/70%	100%/70%
Single Medical Out-of-pocket Maximum (In-network/Out-of-network) (Family = 2x)	\$3,100/\$6,000	\$3,000/\$5,000	\$3,500/\$5,500	\$1,100/\$5,000	\$2,000/\$5,000	\$2,500/\$5,500

PRESCRIPTION DRUG BENEFITS: (REQUIRED)**

Generic/Preferred Brand/Brand Copayment)

\$7/\$15/\$35 \$10/\$25/\$50 \$15/50%

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

****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.

OXFORD HSA DIRECT OPTIONS (ALL INFORMATION IS SUBJECT TO HOME OFFICE APPROVAL)

Vision Domestic Partner
 Premium Dental Rider Physical Therapy 90 Rider (30 visits standard)
 Enhanced Dental Rider

III. ALL QUESTIONS MUST BE ANSWERED

1. 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 name of insurance carrier(s)

2. 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 _____

3. Has your firm been uninsured for 3 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 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

It is understood that, except as provided under applicable regulations, no individual shall become insured while not actively at work on a full-time basis, or retired, and only full-time employees and retiree's are eligible. A full-time employee is one who regularly works at least 25 hours per week at his employer's place of business. It is further understood that no agent has power on behalf of Oxford Health Insurance, Inc. to make or modify any request or application for insurance or to bind Oxford Health Insurance, 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 Insurance, 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 _____

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.

Print Name of Officer, Partner or Proprietor

Signature of Officer, Partner or Proprietor

Witness to Signature