

Connecticut Large Group Application - OHP

Oxford Health Plans (CT), Inc.

Corporate Address: 48 Monroe Turnpike, Trumbull, CT 06611 • www.oxfordhealth.com

I. GENERAL INFORMATION

1. Full legal name of firm:

2. Address of firm:
 (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:
 Area Code

d. Fax Number:
 Area Code

e. Email 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:
 Area Code

e. Fax Number:
 Area Code

5. Start date of business:

6. Full legal name & 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:

a. Name:

b. Address:

The definition of a Retired Employee is:

- an employee who is retired on pension by the employer.
- an employee who is retired 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)

6. Number of Employees Eligible on Effective Date: Full-Time Employees _____ Part Time Employees _____ Retired Employees _____

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.

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)

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" means 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

1. Please check the box corresponding to the product selected:

- | | | |
|---------------------------------------|--|--|
| <input type="checkbox"/> HMO | <input type="checkbox"/> HMO Plan Select | <input type="checkbox"/> Other: _____
(subject to Home Office approval) |
| <input type="checkbox"/> Freedom Plan | <input type="checkbox"/> Freedom Plan Select | |

2. Please check the box corresponding to the network selected:

- | | |
|----------------------------------|--|
| <input type="checkbox"/> Freedom | <input type="checkbox"/> Other: _____
(subject to Home Office approval) |
|----------------------------------|--|

3. Please complete section below:

Office copayment: _____
 Deductible: _____
 Coinsurance (%): _____
 Coinsurance Maximum : _____
 Family Multiple (2,2.5,3): _____
 UCR level: _____

Note: If more than one product/plan design has been selected, please attach a photocopy of this selection to your application

4. Additional Benefit Information:

- | | | |
|---------------------|--|--|
| Prescription Plan : | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Contraceptives: | <input type="checkbox"/> Yes (Standard) | <input type="checkbox"/> No (Qualified State exempt groups only) |
| Mail order: | <input type="checkbox"/> 1x Retail copayment/90 day supply | <input type="checkbox"/> 2x Retail copayment/90 day supply |

Copayment Information:
 Tier 1: _____
 Tier 2: _____
 Tier 3: _____
 Prescription Deductible (if applicable) _____

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

- | | | |
|--|--|--|
| Vision: | <input type="checkbox"/> \$50 exam/\$70 appliances | <input type="checkbox"/> \$50 exam/\$200 appliances |
| <input type="checkbox"/> Prosthetics | <input type="checkbox"/> Dental Plan Premium | <input type="checkbox"/> Hospital Room Copay _____
<small>PLEASE SPECIFY</small> |
| <input type="checkbox"/> Enhanced Chiropractic | <input type="checkbox"/> Dental Plan Enhanced | <input type="checkbox"/> Emergency Room Copay _____
<small>PLEASE SPECIFY</small> |
| <input type="checkbox"/> Unlimited Durable Medical Equipment | <input type="checkbox"/> Skilled Nursing Facility | <input type="checkbox"/> Alternative Medicine _____
<small>PLEASE SPECIFY</small> |
| <input type="checkbox"/> 90 Visit Physical Therapy | | |

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 Company

Signature of Authorized Officer of Company

Title of Officer of Company

Date

V. COBRA & EXTENSION OF BENEFITS DATA

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? _____

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.

VI. 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 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. Further, I hereby certify on behalf of the Applicant that the Applicant has not had a health insurance policy terminated within the past 12 months due to failure to pay premiums.

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

Title of Officer of Applicant

X

Witness

X

Duly Licensed Resident Agent/Broker

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