UnitedHealthcare®
Oxford

New York HMO Small Group (2-50) Application – OHP

Oxford Health Plans (NY), Inc. ▪ www.oxfordhealth.com
Mailing Address: Group Enrollment Department, 14 Central Park Drive, Hooksett, NH 03106

I. GENERAL INFORMATION

1. **Full legal name of group:**

2. **Primary address of group:**
   (Street Address
   City, State, ZIP Code)
   No P.O. Box

3. **Plan Administrator/contact:**
   - a. Name
   - b. Title
   - c. Address
     (If different from primary)
     City, State, ZIP Code
   - d. Phone Number Ext.
   - e. Fax Number
   - f. Email Address
   - g. Add'l Contact Name/ Address

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

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

6. **Nature of business:**

7. **SIC code:**

8. **Tax identification number:**

II. ADMINISTRATIVE INFORMATION

The term "coverage" means the benefits provided by Oxford, pursuant to the Group Certificate of Coverage. To be eligible for small group coverage, you must be located in a county where we offer this Oxford product and have at least 2 but not more than 50 eligible employees.

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. How many total employees does this group have? _____

   Total employees means the average number of employees, including seasonal and/or part time employees, during the prior calendar year.
5. How many eligible employees does this group have? _____

   Eligible employees: Active permanent employees of the employer and of all subsidiaries or affiliates of a corporate employer who work **20 or more** hours per week and are eligible for health benefits through the employer's group health plan. Eligible employees do not include:
   - any person who performs services for the company who is reported on an IRS 1099 form (such a person is not an employee and is not eligible for coverage) or
   - any former employee who is covered through retiree benefits, COBRA or state continuation.

   An employer may elect to offer coverage to a class of employees based on conditions pertaining to employment: geographic situs of employment, earnings, method of compensation, hours and occupational duties. Employees who work less than 20 hours per week are not eligible employees and may not enroll in any Oxford products. If coverage is limited to specific class(es) of employees, the classes must be specified in response to question 13 below.

   If the employer does not offer group health coverage to all eligible employees, eligible employees should include (1) the number of eligible employees who work in the state of New York and (2) if the employer offers Oxford coverage to out-of-state employees, the number of out-of-state eligible employees.
6. Total number of employees being offered coverage through this product: _____

   Of the eligible employees who work 20 or more hours per week, please list all employees who will be offered coverage under this policy. If coverage is limited to specific class(es) of employees, the classes must be specified in response to question13 below.

   Groups seeking to purchase insurance, rather than HMO coverage, also must meet the minimum participation requirements for coverage. A minimum of 51% of all eligible employees after valid waivers must be enrolled, and Oxford Health Insurance Inc. must be the sole carrier for all eligible employees who work in New York and are eligible employees and offered coverage by the group.
7. If the employer offers retiree coverage, how many eligible retired former employees does this group have? _____

   Integration with Medicare benefits: Health benefits covered by Medicare Part A and B are carved out for retired employees aged 65 or over and their dependents aged 65 or over, if the group offers retiree coverage.
8. Total number of employees and former employees enrolling: _____

   Enrolling means the total number of eligible employees, COBRA or state continuation enrollees, and retired employees (if applicable) accepting coverage with any Oxford product.
   a. of those former employees enrolling, how many are retired? _____
   b. of those former employees enrolling, how many are enrolling through COBRA or state continuation? _____
9. Total number of employees waiving coverage for the following reasons:
   a. A spouse's health benefit plan: _____
   b. Medicare: _____
   c. Medicaid: _____
   d. Veteran's coverage: _____
   e. All other waivers: _____
10. Total number of valid waivers (a - d): _____
11. Is the Employer offering other group or HMO coverage to employees who are eligible for coverage in an Oxford product? __ YES __ NO

    Please list other current or past group health or HMO coverage offered by Employer in the last three years:

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

12. Is your group subject to COBRA (20 or more total employees during at least 50% of the working days in the previous calendar year)? __ YES __ NO
13. Eligible employee class(es), Waiting Period and Termination:

    If coverage is being limited to particular class(es) of employees, please specify class definition(s) below. An employer may elect to offer coverage to a class of employees based on conditions pertaining to employment: geographic situs of employment, earnings, method of compensation, hours, and occupational duties. Although an Employer may establish a class of employees who work less than 20 hours per week, Oxford products are not available to employees who work less than 20 hours per week.

    If classes and waiting periods are not specified below, all eligible employees who work 20 or more hours per week will be eligible for group health benefits under an Oxford policy without a waiting period.

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

HMO/Liberty Network

Referrals are required for this plan design.

Option	❑ Plan 1
Copayment: a. PCP b. Specialist	 $30 per visit $50 per visit
Single Deductible	N/A
Family Deductible	N/A
Coinsurance	N/A
Outpatient Facility Copayment	$150
Inpatient Facility Copayment	$500 per day to a maximum of $1,000 per continuous confinement.
Emergency Room	$150

Additional Benefit Options:

❑ Vision
❑ Domestic Partner
❑ Coverage for Biologically Based Mental Illness and Children with Serious Emotional Disturbances
❑ Mandated Offering – Dependent Age Extension to 29
❑ Unlimited Mental Health**

**Required for employers who average 51 or more total emloyees, including seasonal and/or part-time employees, during the prior calendar year.

Please select optional prescription drug coverage:

Options	Tier 1	Tier 2	Tier 3	Mail-Order	Deductible*
❑ Option 1	$15 copayment	$35 copayment	$75 copayment	2.5x copayment	$100
❑ Waived Coverage	N/A	N/A	N/A	N/A	N/A

*Deductible applies to Tier 2 and Tier 3 drugs.

Contraceptives ❑ Yes (Standard) ❑ No (Qualified State Exempt Groups Only)

Medicare Part D 28% Subsidy – For the prescription plan design above, do you currently participate or plan to participate with the 28% Government Subsidy for your Medicare eligible retirees? ❑ Yes ❑ No

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 Payee:			
2. Payee's Oxford Broker Code (Required):			
3. Payee's Social Security # or Federal Tax ID # :			
4. Name of Writing Agent (Required if Payee is a company):			
5. Writing Agent's Oxford Broker Code (Required if Payee is a company):			
6. Commission Split %:			
7. Sales Representative:			
Comments:			

VI. CONSENT

AUTHORIZATION FOR BROKER TO ACT AS BENEFITS ADMINISTRATOR

The undersigned hereby requests Oxford 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 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 _____.

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 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.

VII. 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? _____

VIII. APPLICANT AGREEMENT

Date

This Application and the premium rates proposed by Oxford are subject to 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. We reserve the right to modify rates in the event a plan design must be modified as a result of any change, modification or clarification in law. We also retain the right to correct typographical errors or discrepancies prior to the effective date of coverage, and take other actions (for example due to a misrepresentation of a material fact) as permitted by applicable state law.

I, the undersigned, on behalf of the above named company (the "Applicant") am applying for small group health coverage and understand that the information provided will be used to determine eligibility for coverage, premium rates and for other purposes. I confirm that all information gathered herein is accurately represented, complete, and that the Applicant is not aware of any information that was not disclosed.

The Applicant confirms that we employ no more than 50 eligible active permanent employees and no fewer than 2 eligible active permanent employees. The Applicant understands that 1099-compensated individuals are not eligible for group coverage with Oxford.

The Applicant understands that this application may be chosen for an audit to confirm the information provided. Audits may be conducted before or after enrollment. If documents reviewed or submitted during an audit show that the information provided on an application was false or that the group does not meet underwriting requirements, the group will not be enrolled (audit completed prior to enrollment) or will be terminated (audit completed post enrollment).

The Applicant understands that other audits may be conducted while the Group Policy and Group Enrollment Agreement is in effect and agrees that all documents or other information that may impact coverage or premiums will be available for inspection.

The Applicant hereby acknowledges and understands that this Application does not constitute any obligation by Oxford to offer coverage and no insurance will be effective unless and until the application is formally accepted, in writing, by the Oxford entity underwriting the 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. 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 completion and/or submission of this Application. Further, I hereby certify on behalf of the Applicant that the Applicant has not had a group health policy or health maintenance organization contract terminated within the past 12 months due to failure to pay premiums.

If coverage is formally accepted, the Applicant understands that this application and any subsequent addenda (including, but not limited to, any member application forms and renewal certifications) will become part of the Group Policy and Group Enrollment Agreement issued by Oxford. Any material misrepresentation within the application or the addenda (whether intentional or unintentional) may subject the group to termination or other action permitted by law. By signing below, the Applicant agrees to be bound by the terms and conditions of the Group Policy and Group Enrollment Agreement. The plan documents (including, but not limited to, the application, policy certificate(s) and riders) will determine the contractual provisions, including procedures, exclusions and limitations relating to the plan, and will govern in the event they conflict with any benefits comparison, summary of coverage or other description of the plan.

The Applicant agrees to offer coverage to all eligible employees and that only those employees or former employees and their spouses or dependants who are eligible for coverage will be enrolled.

By signing below, you are signing the group application on behalf of the group applying for coverage and stating that (1) I am the Applicant or the agent for the Applicant and am authorized to sign this Group Application and (2) the Applicant will be legally bound by the terms and conditions of the application, this authorization and the plan documents.

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.

Dated at:_____this_____day of_____ 20_____.

_____

Full legal name of firm:_____

X_____

SIGN HERE Signature of Authorized Company Representative Title Date

X_____

Witness

Group Name: _____
Policy #: _____

Oxford Health Plans
14 Central Park Drive
Hooksett, NH 03106
Attn: NY Small Group Enrollment Department

Dear Oxford,

Enclosed is the documentation you requested to verify my group's eligibility for group healthcare coverage in New York.

Below, I have indicated the number of eligible employees, my group's official filing status in New York State, and the documentation I have enclosed.

Number of eligible employees: _____

Official Group Filing in NY	Required Documentation*	Description
❑ New Corporation	Articles of Incorporation and W4 for each employee	Made up of shareholders who transfer money, property, or both for the corporation's capital stock.
❑ Existing Corporation	NYS-45 (indicating all eligible employees)	
❑ New Partnership	Partnership Agreement and W4 for each employee	A relationship that exists between two or more people who join to carry on a trade or business. Each person contributes money, property, labor, or skill, and each expects to share in the profits and losses of the business.
❑ Existing Partnership	K1 for each partner and NYS-45 (indicating all eligible non-partner employees)	
❑ NYSHIPP Approved Organization	NYSHIPP Certificate	The New York State Health Insurance Partnership Program (NYSHIPP) was established by the New York State Department of Health to assist eligible employees and sole proprietors without employees in purchasing small group health insurance policies for their full-time employees and dependents.
❑ New Proprietorship	W4 for each employee	An unincorporated business that is owned by one individual.
❑ Existing Proprietorship	Schedule C and NYS-45 (indicating all eligible employees)	
❑ New Subchapter S Corporation	CT6 and W4 for each employee	A domestic corporation that is formed to avoid double taxation. An S corporation is generally exempt from federal income tax. Its shareholders include on their tax returns their share of the corporation's separately stated items of income, deduction, loss, and credit, as well as their share of non-separately stated income or loss.
❑ Existing Subchapter S Corporation	1120S or K1 and NYS-45 (indicating all eligible employees)	
❑ New Limited Liability Corporation	Articles of Incorporation and W4 for each employee	May be classified as a partnership or corporation.
❑ Existing Limited Liability Corporation	NYS-45 (indicating all eligible employees)	

***Only fully executed documentation will be accepted.**

_____ _____ _____ _____

Signature of Authorized Employer Group Official Printed Name of Signee Date

New York Member Enrollment Form – OHP

MAILING ADDRESS: P. O. Box 7085, Bridgeport CT 06601 • 1-800-444-6222 • *www.oxfordhealth.com*

UnitedHealthcare®
OXFORD®

THANK YOU FOR CHOOSING AN OXFORD PRODUCT
FOR YOU AND YOUR FAMILY.

IMPORTANT:

PLEASE PRINT AND PRESS DOWN FIRMLY WHEN COMPLETING THIS FORM.

IN ORDER TO PROCESS THE ATTACHED FORM AND BEGIN COVERAGE, ALL FIELDS MUST BE COMPLETED ACCURATELY AND IN ITS ENTIRETY.

BE SURE TO:

- Use only blue or black ballpoint pen
- Enter all dates using the MM/DD/YYYY format
- Employer and employee signatures are required
- List any coordinating coverage (coverage in addition to this coverage)
- List any coverage you had prior to this coverage
- Attach disability paperwork, if applicable
- Check “full-time student” in the child column if the child is between the ages of 19-23 and a full-time student at an accredited institution
- Submit this form within 31 days of the requested effective date or within 60 days of the qualifying event for COBRA or State Continuation

IF YOU HAVE ANY QUESTIONS,
PLEASE FEEL FREE TO CALL CUSTOMER SERVICE AT

1-800-444-6222

New York Member Enrollment Form – OHP

UnitedHealthcare® OXFORD®

MAILING ADDRESS: P. O. Box 7085, Bridgeport CT 06601 • 1-800-444-6222 • *www.oxfordhealth.com*

A. Group Information (To be completed by the employer)

Please print neatly using black or blue ballpoint pen • ALL DATES MUST BE: MM/ DD/YYYY

Group Number	Group Name	Plan CSP	Billing Group	Date of Hire	Effective Date	Occupation
				/ /	/ /	

☐ On Leave of Absence ☐ Union Employee	☐ Retired ☐ Disabled	COBRA/SC Qualifying Event	Event Date / /	**Employer Signature** X	Date / /

B. Applicant Details (To be completed by the employee)

	Employee/Subscriber	Spouse	Child	Child
Social Security Number:				
Last Name:				
First Name, Middle Initial:				
Date of Birth: (MM/DD/YYYY)	/ /	/ /	/ /	/ /
Gender and Disability Status: (Check appropriate boxes.)	☐ M ☐ F / ☐ Disabled	☐ M ☐ F / ☐ Disabled	☐ M ☐ F / ☐ Disabled	☐ M ☐ F / ☐ Disabled
Primary Care Physician (PCP) ID Number: PCP Name: (If an existing patient of PCP, check "Yes".)	☐ Yes	☐ Yes	☐ Yes	☐ Yes
Check all that apply:		☐ Domestic Partner	☐ Full-time Student	☐ Full-time Student
Prior Carrier (List coverage prior to this.) ☐ Same for all — Carrier: / Policy Number: / From Date / Thru date::		/ / / /	/ / / /	/ / / /

C. Coordination of Benefits

		Employee/Subscriber	Spouse	Child	Child
Medicare Coverage	Check appropriate box and list effective date:	☐ Part A / / ☐ Part B / / ☐ Part D / /	☐ Part A / / ☐ Part B / / ☐ Part D / /	☐ Part A / / ☐ Part B / / ☐ Part D / /	☐ Part A / / ☐ Part B / / ☐ Part D / /
Pharmacy ☐ Same for all **Effective Date**: / /	Policy Number: Carrier: Policy Holder: Group Number:	BIN: PCN:	BIN: PCN:	BIN: PCN:	BIN: PCN:
Medical ☐ Same for all	Policy Number: Carrier: Policy Holder: Effective Date:	/ /	/ /	/ /	/ /

A. I understand that my enrollment and benefits are in accordance with those described in the applicable Oxford Health Plans (NY), Inc. HMO Certificate. I understand that, in order to receive HMO benefits, I and any enrolled dependents must seek care through our Oxford affiliated primary care physician or through an Oxford-affiliated specialist physician with an authorized referral from the primary care physician if required. I authorize any health provider or insurer to furnish Oxford Health Plans (NY), Inc. any records concerning me or any enrolled member of my family for whom information is requested. A photographic copy of this authorization shall be valid as the original. 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, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulentinsurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

B. I understand that in addition to the applicable Oxford Health Plans (NY) Inc. HMO Certificate, my enrollment and benefits are in accordance with those described in the applicable Oxford Health Insurance, Inc. Supplemental Freedom Plan Certificate. I understand that, in order to receive HMO benefits, I and any enrolled dependents must seek care through our Oxford affiliated primary care physician or through an Oxford-affiliated specialist physician with an authorized referral from the primary care physician if required. I further understand that if I do not adhere to these requirements for HMO benefits, I will be eligible only for traditional health insurance coverage under the terms of the Oxford Health Insurance, Inc. Supplemental Freedom Plan Certificate. 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, or conceals for the purpose of misleading, 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 five thousand dollars and the stated value of the claim for each such violation.

Employee's Address (Apt #) City State Zip	**Employee's Signature** X	Date / /

Oxford Health Insurance, Inc.

New York Health Benefits Waiver of Coverage

Mailing Address: Enrollment Dept. ■ 14 Central Park Drive ■ Hookset, NH 03106 ■ 1-888-201-4216 ■ www.oxfordhealth.com

Group Name: _____

Group Policy Number (if known): _____

Employee Name: _____

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced

Date of Employment: _____

Date of Birth: _____

I am employed by and working at least 20 hours per week for the group shown above. I was given the opportunity to enroll in this plan of group health benefits offered by my employer and I refuse coverage.

Reason for Refusal (please check all appropriate boxes)

❑ I have other coverage from:

- ❑ My spouse's employer
- ❑ Medicare
- ❑ Medicaid
- ❑ Veteran's Administration
- ❑ Union health plan
- ❑ Another carrier's group health plan sponsored by this employer
- ❑ Another source of coverage (please specify): _____

REQUIRED INFORMATION: _____
Name of carrier Policy number

❑ Other reason (please explain): _____

I certify that all information provided in this form is true and complete. By refusing group health benefits, I acknowledge that I and/or my dependents may have to wait until the plan's next anniversary date to be enrolled for group coverage.

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. Any material misrepresentation within this waiver may subject the group to termination.

Signature of Employee Date

Signature of Benefits Administrator Date

UnitedHealthcare®
Oxford

Addition/Termination Change Form

P. O. Box 7085, Bridgeport CT 06601 ▪ 1-800-444-6222
Many transactions can be completed online at the employer area of our website *www.oxfordhealth.com*

Please print neatly using black or blue ballpoint pen

ALL DATES MUST BE: MM/DD/YYYY

A. Employer/Employee Information (To be completed by the employer)

Group ID Number:	Group Name:
Employee Insurance ID Number:	Employer Signature X Date / /
Employee Name:	

B. Transaction	Effective Date	Required Information
☐ **Termination**	/ /	**Who:** ☐ Employee ☐ Spouse/Partner ☐ Dependent(s) ☐ NY Young Adult **Reason:** ☐ Left Employer ☐ Discontinue COBRA ☐ Switched Plans ☐ Discontinue NY Young Adult ☐ Other:
☐ **Change** Address changes can be done online or by calling Oxford.	/ /	Who: Last Name: First Name: Effective Date: / / Date of Birth: / / Other: SS#: Middle Intial: Gender: ☐ M ☐ F
☐ **COBRA or State Continuation**	/ /	**Who :** ☐ Employee ☐ Spouse/Partner* ☐ Dependent(s)* **Reason:** ☐ Left Employer ☐ Hours Reduction ☐ Other: Date of Event: / / *A **New Member Enrollment Form** is required for: Loss of Dependent Status, Divorce/Separation, or Death of Subscriber.
☐ **Transfer** Complete entire section	/ /	New Plan CSP: New Billing Group: Reason: Retiree Drug Subsidy: ☐ Yes ☐ No Actively Working: ☐ Yes ☐ No Enrolled in Medicare Part: ☐ A ☐ B ☐ D
☐ **Addition** Complete WHO, REASON and SECTION C below	/ /	**Who :** ☐ Spouse ☐ Civil Union ☐ Domestic Partner ☐ Dependent(s) **Reason:** ☐ Open Enrollment ☐ Loss of Coverage ☐ Birth/Adoption ☐ Other: ☐ Date of Marriage ☐ Date of Civil Union ☐ Date of Partnership

C. Additional Information	Spouse	Dependent	Dependent
Social Security Number:			
Last Name:			
First Name, Middle Initial:			
Date of Birth: (MM/DD/YYYY)	/ /	/ /	/ /
Gender and Disability Status:	☐ M ☐ F / ☐ Disabled	☐ M ☐ F / ☐ Disabled	☐ M ☐ F / ☐ Disabled
Primary Care Physician (PCP) ID Number: PCP Name: (If an existing patient, check "Yes".)	☐ Yes	☐ Yes	☐ Yes
Check all that apply:	☐ Actively employed ☐ Not actively employed	☐ Full-time Student (Age 19 - 23)	☐ Full-time Student (Age 19 - 23)
Prior Carrier What coverage you had prior to this. Policy Number: Carrier: From Date: Thru Date:	/ / / /	/ / / /	/ / / /

D. Coordination of Benefits		Spouse	Dependent	Dependent
Medicare	Check appropriate box and list effective date:	☐ Part A / / ☐ Part B / / ☐ Part D / /	☐ Part A / / ☐ Part B / / ☐ Part D / /	☐ Part A / / ☐ Part B / / ☐ Part D / /
Pharmacy ☐ Same for all Effective Date: / /	Policy Number: Carrier: Policy Holder: Group Number:	BIN: PCN:	BIN: PCN:	BIN: PCN:
Medical ☐ Same for all	Policy Number: Carrier: Policy Holder: Effective Date:	/ /	/ /	/ /

ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR INSURANCE IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES

Employee Signature X _____ **Date** / /