UnitedHealthcare Oxford

Application for a Small Employer Health Benefits Policy – OHP

Oxford Health Plans (NJ), Inc. ("OHP")
Mailing Address: 14 Central Park Drive, Hooksett, NH 03106 ▪ www.oxfordhealth.com

Please print or type

Policy Number (OHP 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):

2. Tax Identification Number:

3. Main address:
   Street
   City State Zip Code

   Mailing address:
   Street
   City State Zip Code

   Telephone & Facsimile: Fax

4. Name of correspondent:

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 the 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 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? _____

I. POLICYHOLDER INFORMATION (CONT.)

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

II. SPECIFICATIONS FOR COVERAGE

A. HEALTH BENEFITS

Product: ❑ HMO[1] ❑ HMO Select[1] ❑ HMO HSA[1] (Plans 17-20) **Network**: ❑ Liberty ❑ Freedom

PLAN OPTIONS

Options	❑ Plan 1*	❑ Plan 2*	❑ Plan 3*	❑ Plan 4	❑ Plan 5	❑ Plan 6	❑ Plan 7	❑ Plan 8	❑ Plan 9	❑ Plan 10
Copayment	$15	$20	$30	$15/$30	$30/$50	$15/$30	$25/$40	$30/$50	$30	$30
Deductible	N/A	N/A	N/A	N/A	N/A	$500	$1,000	$2,000	$500	$1,000
Coinsurance	100%	100%	100%	100%	100%	90%	80%	70%	90%	80%
MOOP	N/A	N/A	N/A	N/A	N/A	$1,500	$3,000	$5,000	$1,500	$3,000
Inpatient Copay	$150	$250	$300	$150	$300	D&C	D&C	D&C	D&C	D&C
Outpatient Copay	-	$20	$30	$30	$50	$30	$40	$50	$30	$30

Options	❑ Plan 11	❑ Plan 12	❑ Plan 13	❑ Plan 14	❑ Plan 15	❑ Plan 16	❑ Plan 17	❑ Plan 18	❑ Plan 19	❑ Plan 20	❑ Plan 21
Copayment	$30/$50	$15/$30	$30/$50	$50/$50	$25/$40	$30/$50	$30/$50	$20/$30	$25/$40	$50	$40/$60
Deductible	$1,000	N/A	N/A	N/A	$1,000	$2,000	$2,500	$1,500	$2,000	$2,500	$2,500
Coinsurance	80%	100%	100%	N/A	100%	100%	100%	100%	90%	50%	100%
MOOP	$3,000	N/A	N/A	N/A	$1,000	$2,000	$5,000	$3,000	$4,000	$5,800	$2,500
Inpatient Copay	D&C	$150	$300	$500	D&C	D&C	$500	$300	D&C	D&C	D&C
Outpatient Copay	$50	$150	$300	$500	D&C	D&C	$250	$150	D&C	D&C	D&C

*Not available with HMO Select [1]**Deductibles and out-of-pocket accumulation periods are on a ❑ calendar year basis ❑ contract year basis.**

PRESCRIPTION DRUG BENEFITS

Options	Tier 1	Tier 2	Tier 3	Deductible	Oral Contraceptives
❑ 1 (Base Plan)	50%	50%	50%	N/A	❑ Yes ❑ No**
❑ 2	Plan Copayment	Plan Copayment	Plan Copayment	N/A	❑ Yes ❑ No**
❑ 3	$5	$15	$50	❑ $0 ❑ $50 ❑ $100	❑ Yes ❑ No**
❑ 4	$7	$20	$50	❑ $0 ❑ $50 ❑ $100	❑ Yes ❑ No**
❑ 5	$7	$15	$25	N/A	❑ Yes ❑ No**
❑ 6	$7	$15	$35	❑ $0 ❑ $50 ❑ $100	❑ Yes ❑ No**
❑ 7	$10	$25	$50	❑ $0 ❑ $50 ❑ $100	❑ Yes ❑ No**
❑ 8	$15	50%	50%	❑ $0 ❑ $50 ❑ $100	❑ Yes ❑ No**
❑ 9	$15	$30	$60	$100	❑ Yes ❑ No**
❑ 10	$15	$35	$75	❑ $0 ❑ $50 ❑ $100	❑ Yes ❑ No**
❑ 11 (HSA HMO only)	50%	50%	50%	Combined with Medical	❑ Yes ❑ No**
❑ 12 (HSA HMO only)	$15	$35	$75	Combined with Medical	❑ Yes ❑ No**
❑ 13 (HSA HMO only)	$10	$25	$50	Combined with Medical	❑ Yes ❑ No**
❑ 14 (HSA HMO only)	$25	$50	$75	Combined with Medical	❑ Yes ❑ No**
❑ 15	$25	$50	$75	❑ $0 ❑ $50 ❑ $100	❑ Yes ❑ No**

**Qualified State Exempt Groups Only

OPTIONS

- ❑ Vision Care Rider
- ❑ Enhanced Dental Rider
- ❑ Premium Dental Rider
- ❑ Domestic Partner
- ❑ Hospital Confinement Rider (Plans 1-5)
- ❑ Hospital Confinement Rider (Plans 6-11 and 15 & 16)
- ❑ Physical Therapy 90 Rider (Plans 17-20)

B. POS FLEX MEDICAL PLANS

Network: ❑ Freedom ❑ Liberty

Access: ❑ Gated ❑ Non-gated

Options		❑ Plan 1	❑ Plan 2	❑ Plan 3	❑ Plan 4	❑ Plan 5	❑ Plan 6
In Network	Copayment	$20/$30	$25/$40	$30/$50	$25/$40	$30/$50	$50/$50
	Deductible	N/A	N/A	N/A	$1,000	$1,500	$2,500
	Coinsurance	N/A	N/A	N/A	80%	80%	80%
	MOOP (2.0x family)	N/A	N/A	N/A	$3,000	$3,500	$4,500
	Inpatient copay	N/A	$250	$300	D & C	D & C	D & C
	Outpatient copay	$50	$125	$125	D & C	D & C	D & C
Out-of-network	Deductible	$2,000	$2,500	$2,500	$3,000	$4,000	$5,000
	Coinsurance	70%	70%	70%	60%	60%	50%
	MOOP (2.0x family)	$5,000	$6,250	$6,250	$7,500	$10,000	$12,500

POS FLEX RX PLANS

Options	Tier 1	Tier 2	Tier 3	Deductible	Oral Contraceptives
❑ Plan 1	50%	50%	50%	❑ $0 or ❑ $100	❑ Yes or ❑ No
❑ Plan 2	$15	$35	$75	❑ $0 or ❑ $100	❑ Yes or ❑ No
❑ Plan 3	$10	$25	$50	❑ $0 or ❑ $100	❑ Yes or ❑ No
❑ Plan 4	$25	$50	$75	❑ $0 ❑ $50 or ❑ $100	❑ Yes or ❑ No

OPTIONS:

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

C. PRIMARY ADVANTAGE

PLAN OPTIONS

Options	❑ Plan 1	❑ Plan 2
Copayment	$25/Deductible then $50	$30/Deductible then $60
Deductible	$1,500	$2,500
Coinsurance	N/A	N/A
Inpatient Copayment	Deductible then $250 Copayment up to 5 days per admission	Deductible than $500 Copayment up to 5 days per admission
Outpatient Copayment	Deductible then $150 Copayment	Deductible then $250 Copayment

PRESCRIPTION DRUG BENEFITS

Options	Tier 1	Tier 2	Tier 3	Deductible	Oral Contraceptives
❑ Plan 1	50%	50%	50%	N/A	❑ Yes ❑ No
❑ Plan 2	$15	Deductible then 50% up to $250 per prescription	Deductible then 50% up to $250 per prescription	Combined with Medical	❑ Yes ❑ No
❑ Plan 3	$15	Deductible then 50% up to $400 per prescription	Deductible then 50% up to $400 per prescription	Combined with Medical	❑ Yes ❑ No

OPTIONS

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

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 the 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 three 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 of Coverage 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

A full-time employee is one who regularly works at least 25 hours per week at his or her employer's place of business. It is further understood that no agent has power on behalf of Oxford to make or modify any request or application for insurance or to bind Oxford 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. 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_____

_____ _____
Print name of Officer, Partner or Proprietor Signature of Officer, Partner or Proprietor

_____
Witness to Signature

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.

UnitedHealthcare Oxford

New Jersey Small Employer – Member Enrollment/Change Request Form – OHP

Oxford Health Plans (NJ), Inc.
Mailing Address: P.O. Box 7085, Bridgeport, CT 06601-7085 1-800-444-6222 www.oxfordhealth.com

INSTRUCTIONS

Employers – You must complete the Employer Group Information and sections A and K in order for this application to be processed.

Employees – You must complete sections B through K and submit the signature of each Over-Age Child for which a Dependent Under 31 Continuation Election is made in accordance with Section J in order for this application to be processed.

- Please PRINT except when a signature is requested.
- If a dependent is disabled and you want to continue his or her coverage beyond the limiting age, you do not have to make a COBRA/NJSGC or Dependent Under 31 election. Instead, select "Other" in Section A3, and attach proof of disability.
- For provider addresses, include the zip code plus the four digit extension (11 digits)
- If a dependent is a full-time post-secondary student, you must check the box in Section D.
- You can obtain the providers' correct names and addresses from the appropriate provider directory.

Qualifying Events

COBRA and NJSGC
C1. Termination of job or reduction in hours
C2. Employee enrollment in Medicare (COBRA only)
C3. Divorce (COBRA/NJSGC); civil union dissolution (NJSGC)
C4. Death of employee
C5. Loss of dependent child status under the plan
C6. Disability (occurring subsequent to another qualifying event)

Dependent Under 31
D1. Loss of dependent status and otherwise eligible
D2. Re-establish eligibility: residency
D3. Re-establish eligibility: nonresident full-time student
D4. Re-establish eligibility: change in marital status
D5. Re-establish eligibility: change in parental status
D6. Re-establish eligibility: termination of other coverage

CONDITIONS OF ENROLLMENT - APPLICANT ACKNOWLEDGEMENTS AND AGREEMENTS

On behalf of myself and the dependents listed in this Enrollment/Change Request form, I acknowledge that:

1. I authorize any physician or medical professional, hospital, clinic or other medical care institution, carrier, consumer reporting agency, and any employer to give Oxford Health Plans, Inc., or any consumer reporting agency acting on behalf of Oxford Health Plans, Inc., information pertaining to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition relevant to me or a minor dependent applying for coverage. I agree that this authorization shall be valid for 30 months from the date I sign this Enrollment/Change Request form, unless revoked at an earlier date.
2. I agree that, if I revoke this authorization before it expires, such revocation shall not affect any action that Oxford Health Plans, Inc. has taken in reliance on the authorization.
3. I understand I may receive a copy of this authorization if I request one.
4. I agree Oxford Health Plans, Inc. will provide coverage in accordance with the terms of the contract for the group policy.
5. I agree that the provision of coverage and benefits is contingent upon payment of premiums and may be terminated in accordance with the terms of the group policy if premiums are not paid timely. I authorize my Employer to withhold payments from my wages as contribution to the premium, as appropriate.

UnitedHealthcare Oxford

Group Information – To be completed by Employer:		
Group Name:	Group Number:	Contract Specific Package:

New Jersey Small Employer Member Enrollment/Change Request Form – OHP

Oxford Health Plans (NJ), Inc.
Mailing Address: P.O. Box 7085, Bridgeport, CT 06601-7085 1-800-444-6222 www.oxfordhealth.com

A. Type of Activity – To be completed by Employer. ***Refer to instructions on cover before completing this form. Print clearly.***

	Activity – Check all that apply	Effective Date/ Date of Event	Date of Hire/Reason for Change
1. ADD	☐ Enrollment of a new Subscriber ☐ Add Spouse ☐ Civil Union Partner ☐ Add Domestic Partner ☐ Add Dependent Child ☐ Add Over-Age Child as a Dependent Under 31 *(and complete section A 4)*	____/____/____ ____/____/____ ____/____/____ ____/____/____ ____/____/____ ____/____/____	Date of Hire: ____/____/____ _____ _____ _____ _____ _____
2. REMOVE	☐ Employee Withdrawal/Termination ☐ Remove Spouse ☐ Civil Union Partner ☐ Remove Domestic Partner ☐ Remove Dependent Child ☐ Remove Over-Age Child as a Dependent Under 31	____/____/____ ____/____/____ ____/____/____ ____/____/____ ____/____/____ ____/____/____	_____ _____ _____ _____ _____ _____
3. OTHER CHANGE	☐ Name Change ☐ Change Plan ☐ Other ☐ Add/Change Office ID Numbers: Primary/OB/Gyn/ Dentist	____/____/____ ____/____/____ ____/____/____ ____/____/____	_____ _____ _____ _____

4. COVERAGE CONTINUATION

☐ For Employee
- ☐ Total Disability*
- ☐ COBRA/NJSGC
  - Length of Continuation (in months):
  - ☐ 18 ☐ 29
  - Date of Loss of Coverage: ___/___/___
  - Qualifying Event #:_____**
  - Date of Qualifying Event: ___/___/___

**Attach proof of disability*
*** Qualifying event #s: see list in Instructions.*

☐ For Spouse/Civil Union Partner*
- Length of Continuation (in months):
- ☐ 18 ☐ 36
- Date of Loss of Coverage: ___/___/___
- Qualifying Event #:_____**
- Date of Qualifying Event: ___/___/___

**Civil union partners are eligible to make an election pursuant to NJSGC, if applicable.*

☐ For Dependent or Over-age Child
- ☐ COBRA/NJSGC
  - Length of Continuation (in months):
  - ☐ 18 ☐ 36
  - Loss of Coverage: ___/___/___
  - Qualifying Event #:_____**
  - Date: ___/___/___
- ☐ Dependent Under 31
  - Qualifying Event #:_____**

B. Employee Information – to be completed by the Employee

Name (Last, First, MI):

SSN:

Home

Street/Apt:_____

City:_____ State:_____ Zip Code: _____

Birthdate (mm/dd/yyyy):

☐ Male ☐ Female

Phone: (_____)_____

Work

Employer Name:_____

Address:_____

City:_____ State:_____ Zip Code: _____

Phone: (_____)_____

Employment Date: _____/_____/_____

Hours worked per week:_____

Activity

☐ Add ☐ Remove ☐ Continuation ☐ Other Change *If a name change, indicate prior name:*

Primary Name_____ Provider ID #: Current Patient: ☐ Yes ☐ No

Ob/Gyn Name_____ Provider ID #: Current Patient: ☐ Yes ☐ No

Dentist Name_____ Provider ID #: Current Patient: ☐ Yes ☐ No

Other Health Coverage? ☐ Yes ☐ No *If yes:*

Payer Name:

_____

Policy #: _____

Medicare ID#, if any:

Other Rx Coverage? ☐ Yes ☐ No *If yes:*

Payer Name: _____

Policy #: _____

Medicare ID#, if any:

Previous Coverage? ☐ Yes ☐ No

If Yes:

Effective date: _____/_____/_____ Termination date: _____/_____/_____

Payer Name:_____

Policy #:_____

C. Plan Option – To be completed by the Employee

Small Group:

☐ HMO/Liberty Network ☐ HMO Select/Liberty Network

☐ HMO/Freedom Network ☐ HMO Select/Freedom Network

☐ Oxford Ease℠

D. Other Individuals Covered – To be completed by the Employee. *Identify individuals other than yourself for whom you are adding/changing/removing/continuing coverage. Attach additional pages if necessary, dated and signed by you. Attach proof of disability.*

1. ☐ **Spouse** ☐ **Domestic Partner** ☐ **Civil Union Partner**	**2. Child** ☐ Full-Time Student	**3. Child** ☐ Full-Time Student	**4. Child** ☐ Full-Time Student
☐ Add ☐ Remove ☐ Other ☐ Continue Spouse ☐ Continue CU Partner (NJSGC)	☐ Add ☐ Remove ☐ Other ☐ Continue	☐ Add ☐ Remove ☐ Other ☐ Continue	☐ Add ☐ Remove ☐ Other ☐ Continue
Name (last, first, MI) L: ______ F: ______ MI: ______	Name (last, first, MI) L: ______ F: ______ MI: ______	Name (last, first, MI) L: ______ F: ______ MI: ______	Name (last, first, MI) L: ______ F: ______ MI: ______
Birthdate (mm/dd/yyyy):	Birthdate (mm/dd/yyyy):	Birthdate (mm/dd/yyyy):	Birthdate (mm/dd/yyyy):
☐ Male ☐ Female / ☐ Disabled	☐ Male ☐ Female / ☐ Disabled	☐ Male ☐ Female / ☐ Disabled	☐ Male ☐ Female / ☐ Disabled
Social Security Number:	Social Security Number:	Social Security Number:	Social Security Number:
Other Health Coverage ☐ Yes ☐ No *If yes:* Payer Name: ______ Policy #: ______ Medicare ID #: ______	Other Health Coverage ☐ Yes ☐ No *If yes:* Payer Name: ______ Policy #: ______ Medicare ID #: ______	Other Health Coverage ☐ Yes ☐ No *If yes:* Payer Name: ______ Policy #: ______ Medicare ID #: ______	Other Health Coverage ☐ Yes ☐ No *If yes:* Payer Name: ______ Policy #: ______ Medicare ID #: ______
Previous Coverage: ☐ Yes ☐ No *If yes:* Effective: ___/___/___ Termination: ___/___/___ Payer Name: ______ Policy #: ______	Previous Coverage: ☐ Yes ☐ No *If yes:* Effective: ___/___/___ Termination: ___/___/___ Payer Name: ______ Policy #: ______	Previous Coverage: ☐ Yes ☐ No *If yes:* Effective: ___/___/___ Termination: ___/___/___ Payer Name: ______ Policy #: ______	Previous Coverage: ☐ Yes ☐ No *If yes:* Effective: ___/___/___ Termination: ___/___/___ Payer Name: ______ Policy #: ______

Continue on next page

Continue from previous page

1. Spouse, Domestic Partner, Civil Union Partner	2. Child	3. Child	4. Child
Other Rx Coverage: ☐ Yes ☐ No *If yes:* Payer Name: _____ Policy #: _____ Medicare ID #:_____	Other Rx Coverage: ☐ Yes ☐ No *If yes:* Payer Name: _____ Policy #: _____ Medicare ID #:_____	Other Rx Coverage: ☐ Yes ☐ No *If yes:* Payer Name: _____ Policy #: _____ Medicare ID #:_____	Other Rx Coverage: ☐ Yes ☐ No *If yes:* Payer Name: _____ Policy #: _____ Medicare ID #:_____
Primary Care Provider: Provider ID #:_____ Current Patient? ☐ Yes ☐ No	Primary Care Provider: Provider ID #:_____ Current Patient? ☐ Yes ☐ No	Primary Care Provider: Provider ID #:_____ Current Patient? ☐ Yes ☐ No	Primary Care Provider: Provider ID #:_____ Current Patient? ☐ Yes ☐ No
Ob/Gyn Office Provider ID #:_____ Current Patient? ☐ Yes ☐ No	Ob/Gyn Office Provider ID #:_____ Current Patient? ☐ Yes ☐ No	Ob/Gyn Office Provider ID #:_____ Current Patient? ☐ Yes ☐ No	Ob/Gyn Office Provider ID #:_____ Current Patient? ☐ Yes ☐ No
Dentist Office Provider ID #:_____ Current Patient? ☐ Yes ☐ No	Dentist Office Provider ID #:_____ Current Patient? ☐ Yes ☐ No	Dentist Office Provider ID #:_____ Current Patient? ☐ Yes ☐ No	Dentist Office Provider ID #:_____ Current Patient? ☐ Yes ☐ No
Employed? ☐ Yes ☐ No *If YES, complete Section E1*	If last name is different from Employee's, please explain: _____ _____	If last name is different from Employee's, please explain: _____ _____	If last name is different from Employee's, please explain: _____ _____
Home or billing addresses same as Employee? ☐ Yes ☐ No *If NO, complete Section E2*	Living with Employee? ☐ Yes ☐ No *If NO, complete Section F*	Living with Employee? ☐ Yes ☐ No *If NO, complete Section F*	Living with Employee? ☐ Yes ☐ No *If NO, complete Section F*

E. Additional Spouse/Civil Union Partner/Domestic Partner Information – To be completed by Employee. If *not applicable, please mark as "NA."*

1. Employer Name: _____
Employer Address: _____
City, State, Zip Code: _____
Employer Phone: ( )

2a.
Street/Apt: _____
City, State, Zip Code: _____

2b. Please explain why the address is different:
_____
_____

F. Additional Child Information – To be completed by Employee. *Provide information below about children listed in Section D,* **if** *they have a different address from the employee. If multiple children are at an address, you may list them together. Attach additional pages as necessary, dated and signed by you.*

Name(s): _____
Street/Apt: _____
Street/Apt: _____
City, State, Zip Code: _____
Reason: _____

Name(s): _____
Street/Apt: _____
Street/Apt: _____
City, State, Zip Code: _____
Reason: _____

G. Additional Information for Dependent Under 31 Continuation Elections – Provide information below about children listed in Section D for whom a Dependent Under 31 continuation election is being made.

This Continuation Election is being made:
☐ During Continuous Open Enrollment for Dependent Under 31 elections
☐ Within 30 days prior to the attainment of the limiting age (when the Dependent will become an Over-Age Child)

H. Race/Ethnicity – to be completed by the Employee, at his/her option. *NOTE: your response is appreciated but NOT required!*

Choose a category that most closely describes you:
☐ American Indian or Alaskan Native
☐ Asian or Pacific Islander
☐ Black, not of Hispanic origin
☐ White, not of Hispanic origin
☐ Hispanic

I. Employee Signature

I represent that all the information supplied in this application is true and complete. I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form. I authorize deductions from my earnings for any contributions required from me.

Signature: _____ Date: _____

J. Over-Age Child's Signature

I represent that all the information supplied in this application regarding the Dependent Under 31 Continuation Election is true and complete. I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form. I hereby agree to make contributions required from me for the Dependent Under 31 Continuation Election.

Signature: _____ Date: _____

K. Employer Verification

The requested activity is believed eligible and is approved by the Employer.
Employer Representative: _____ Date: _____

Representative's Title: _____

UnitedHealthcare®
Oxford

New Jersey Small Employer Health Benefits Waiver of Coverage

Mailing Address: P.O. Box 7085, Bridgeport, CT 06601-7085 ▪ 800-385-9088

Group Policy Number:

Policyholder Name:

Employee Name:

Last First Middle Initial

Social Security Number:

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced

Date of Employment: _____

Date of Birth: _____

I was given the opportunity to enroll in this plan of group health benefits offered by my employer and insured by Oxford Health Plans (NJ), Inc./Oxford Health Insurance, Inc. I refuse the following:

- ❑ Employee, Spouse and Child(ren) coverage
- ❑ Spouse coverage
- ❑ Child(ren) coverage

Reason for Refusal (Please check all appropriate lines.)

- ❑ Other Group Health Plan sponsored by this employer
- ❑ Other Group Health Plan sponsored by another organization
- ❑ Other Group Health Plan sponsored by my spouse's employer
- ❑ Other reasons (please explain) _____

Please identify Group Health Plan(s) and provide name(s) of Policyholder(s), carrier(s) and policy number(s):

Policyholder Name:_____ Policyholder Name:_____

Carrier: _____ Carrier: _____

Policy Number: _____ Policy Number: _____

If you are declining enrollment for yourself or your dependents (including your spouse) because of other Group Health Plan coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If the reason for refusal of coverage is coverage under another Group Health Plan, it is important to provide information concerning that Group Health Plan on this Waiver of Coverage form. If you fail to provide this information on this Waiver of Coverage form and you later become ineligible for such other coverage and then wish to enroll in any of the refused coverages, you will be considered a Late Enrollee and may be subject to the pre-existing conditions exclusion.

I understand that if I later wish to enroll for any of the coverage(s) refused, I will be required to submit an Enrollment Form and Pre-Existing Conditions Statement, and coverage may be subject to a pre-existing conditions exclusion.

_____

Signature of Employee Date

_____

Signature of Benefits Administrator Date

UnitedHealthcare®
Oxford

Oxford Health Insurance, Inc.

New Jersey Small Employer Certification

Mailing Address: NJ Small Group Enrollment Dept. ▪ 14 Central Park Drive ▪ Hookset, NH 03106 ▪ 800-385-9088

For a Group Health Benefits Plan

Employer Name:

Group Policy Number:

Address:

Street

City State Zip Code

EMPLOYEE CENSUS INFORMATION

Please include the following persons in the following list:

a. Employees, owners, partners, officers, and independent contractors who are actively working for the employer on a regular basis, and are paid by the employer on a regular basis, whether or not they are eligible to be covered under the policy.

b. Employees, owners, partners, officers, and independent contractors who are not working, but who are currently covered under the employer's health benefits plan for reasons such as continuation of coverage or total disability.

Please use the following letters to indicate Status:

F: Full-time employee who works 25 or more hours per week

P: Part-time employee who works less than 25 hours per week

T: Temporary employee

I: Independent Contractor

D: Totally Disabled employee

C: Continuee under state or federal law

U: Employee participating in an employee welfare arrangement established pursuant to a collective bargaining agreement

Name	Job Title	Date of Employment	Hours Worked Per Week	Status	Work Location (State)	Gender	Date of Birth

Name	Job Title	Date of Employment	Hours Worked Per Week	Status	Work Location (State)	Gender	Date of Birth

Name	Job Title	Date of Employment	Hours Worked Per Week	Status	Work Location (State)	Gender	Date of Birth

CERTIFICATION AS A SMALL EMPLOYER IN THE STATE OF NEW JERSEY IN ACCORDANCE WITH NEW JERSEY CH. 162

Group Health Benefits Policy Participation

All Questions Must Be Answered

An Eligible Employee is one who works on a full-time basis with a normal work week of 25 or more hours for pay. An employee who works less than 25 hours per week, on a temporary or substitute basis, or an employee participating in an employee welfare arrangement established pursuant to a collective bargaining agreement is not an eligible employee.

Total Number of Eligible Employees _____

Total Number of Eligible Employees applying/enrolling for health benefits coverage _____

Total Number of Eligible Employees waiving health benefits coverage under the policy with coverage under their spouse's coverage, other than individual coverage, Medicare, Medicaid, or NJ Family Care, or any other group Health Benefits Plan through a different employer _____

Total Number of Eligible Employees waiving health benefits coverage under the policy with coverage under a Health Benefits Plan issued by another carrier and offered by the small employer _____

Please separately list the name(s) of the other carrier(s) and the number of employees covered under each:

_____

_____

Total Number of Eligible Employees waiving health benefits coverage under the policy without coverage under a spouse's coverage, other than individual coverage, Medicare, Medicaid, or NJ FamilyCare or any other Health Benefits Plan _____

Total Number of Employees in an ineligible class or classes _____

Is your firm subject to Working Aged Provisions (TEFRA / DEFRA)? ❑ Yes ❑ No

Is your firm subject to the requirements of COBRA? ❑ Yes ❑ No

CERTIFICATION

Please sign and date appropriate section indicating whether or not you meet the definition of a small employer.

Small Employer means, in connection with a Group Health Plan with respect to a Calendar Year and a Plan Year, any person, firm, corporation, partnership, or political subdivision that is actively engaged in business that employed an average of at least two but not more than 50 eligible Employees on business days during the preceding Calendar Year and who employs at least two Employees on the first day of the Plan Year, and the majority of the Employees are employed in New Jersey. All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer. In the case of an employer that was not in existence during the preceding Calendar Year, the determination of whether the employer is a small or large employer shall be based on the average number of Employees that it is expected that the employer will employ on business days in the current Calendar Year.

I certify that the information provided to Oxford is true and complete. I understand that if the above information is not complete or is not provided to Oxford in a timely manner, then health benefits coverage does not have to be offered or continued. I further understand that incomplete or untrue information may void health benefits coverage.

I understand that I and my employees may be subject to fines if an employee who is a resident of New Jersey and is eligible for coverage under this group health benefits plan is enrolled in an individual health benefits plan issued on or after August 1, 1993.

Any person who includes any false or misleading information on an application or enrollment form or certification for a health benefits plan is subject to criminal and civil penalties.

_____

Signature of Officer, Partner or Owner *Title* *Date*

_____

Print Name of Officer, Partner, or Owner

_____

Signature of Witness *Date*

I certify that I am not a Small Employer in the State of New Jersey, as defined above.

_____

Signature of Officer, Partner or Owner *Title* *Date*

_____

Print Name of Officer, Partner, or Owner

_____

Signature of Witness *Date*

UnitedHealthcare®
Oxford

New Jersey Small Group (2-50) – OHI and OHP Attachment A

UNDERWRITING GUIDELINES

The following underwriting guidelines must be met for Oxford Health Insurance, Inc. or Oxford Health Plans (NJ), Inc. ("Oxford") to accept this Application:

A. Oxford must be the sole carrier for the group.

B. Effective dates of coverage are in effect on any given day within a month, as long as all information is received by Oxford in conjunction with the requested effective date. Renewal dates will always be the first of the month.

C. The Employer must contribute at least 10% toward the premium.

D. Class carveouts are allowed as long as the employer is not sponsoring another plan for the excluded employees/classes and the Sole Carrier requirement is met (as stated above). Regarding class carveouts in general, pursuant to new federal rules, please consult your tax professional or attorney.

E. Dual and Triple Options will be allowed. A fourth option will not be allowed for class carveout or any other purpose.

F. All out-of-area enrollments, including Oxford USA℠ enrollment, is limited to 50% of the total enrolled employees.

G. Participation: New Jersey Small Group (2-50) requires 75% net of valid waivers (Medicare, Medicaid, Spousal Coverage and NJ FamilyCare) and Oxford must be the sole carrier offered (as stated above).

H. In establishing the percentage of employee participation, a one-to-one credit shall be given to each employee covered by a spouse's health benefits coverage, Medicare, Medicaid, or NJ FamilyCare.

- For example; a small group has three employees who each have coverage under their spouse's plan. The three employees are to be included in the count for the number of enrolling employees when determining the participation percentage. The employees with coverage under a spouse's plan are considered to have health coverage; and, therefore, count toward the employee participation. In this way, a group is not penalized if they have employees covered by a spouse's health benefits plan, Medicare, Medicaid, or NJ FamilyCare.

I. Documentation Requirements:

a. The New Jersey Wage Reporting (WR-30) Tax Form, the Small Employer Health Benefits Waiver of Coverage (Exhibit T) or other standard accepted forms are required.

b. Employer Certification and HSA Certificate of Understanding are required.

J. There is a grace period of five days from the pended receipt date for forms.

K. If forms are not provided as required, the group will be rejected/terminated.

L. Final rates are based on final enrollment by plan design.

Renewal Requirements

The renewal requirements are the same as those listed above. Recertification of participation, payroll/tax status, and all other requirements must be met.

Oxford reserves the right to audit groups that do not respond to requests for information and to terminate groups either on the basis or audit results or in the event that necessary information is not provided on a timely basis.

Grandfathered business will not be required to give up multiple plan/multiple carrier arrangements that are currently in place until such time as a plan change is requested and approved. The certification/documentation requirements will apply to all renewals.

UnitedHealthcare
Oxford

Dental Enrollment Form

Oxford Health Plans, Inc.

Mailing Address: P.O. Box 7085, Bridgeport, CT 06601-7085 • 1-800-444-6222 • www.oxfordhealth.com

Plan Type: ❑ Premium ❑ Enhanced

To Be Completed By Employer (Please Print)

GROUP NAME	GROUP ID NUMBER	EMPLOYEE'S EFFECTIVE DATE OF COVERAGE
		/ /

EMPLOYER SIGNATURE
X

To Be Completed By EMPLOYEE (Please Print)

LAST NAME	FIRST NAME & MI		
STREET ADDRESS	APT. NO.	HOME PHONE	BUSINESS PHONE
CITY / STATE / ZIP	SOCIAL SECURITY NUMBER	❑ MALE ❑ FEMALE	DATE OF BIRTH MO. DAY YEAR
PRIMARY CARE DENTIST NAME*	PROVIDER CODE		

Dependent Information (Please Print)

SPOUSE'S LAST NAME	FIRST NAME	MI	❑ MALE ❑ FEMALE
PRIMARY CARE DENTIST NAME*	PROVIDER CODE	SOCIAL SECURITY NUMBER	DATE OF BIRTH MO. DAY YEAR
ELIGIBLE CHILD'S LAST NAME	FIRST NAME	MI	❑ MALE ❑ FEMALE
PRIMARY CARE DENTIST NAME*	PROVIDER CODE	SOCIAL SECURITY NUMBER	DATE OF BIRTH MO. DAY YEAR
ELIGIBLE CHILD'S LAST NAME	FIRST NAME	MI	❑ MALE ❑ FEMALE
PRIMARY CARE DENTIST NAME*	PROVIDER CODE	SOCIAL SECURITY NUMBER	DATE OF BIRTH MO. DAY YEAR
ELIGIBLE CHILD'S LAST NAME	FIRST NAME	MI	❑ MALE ❑ FEMALE
PRIMARY CARE DENTIST NAME*	PROVIDER CODE	SOCIAL SECURITY NUMBER	DATE OF BIRTH MO. DAY YEAR

* You must select a General Practice (GP) Dentist from Oxford's Roster of Participating Dentists for each family member.

Do you or your spouse have any other Group Dental Coverage? ❑ Yes ❑ No If yes, please give:

Name of Group Administrator/Plan ______________________________ Policy # ____________________

I understand that my enrollment and benefits are in accordance with those described in the Oxford's Dental Rider. I agree to choose a participating Oxford General Practice Dentist for my primary dental care and to seek any necessary specialty care through Oxford participating Dental Specialists. I authorize any provider or insurer to furnish Oxford with any records concerning me or any member of my family for whom information is required. A photographic copy of this authorization shall be as valid as the original. I agree to submit any disputes with Oxford in accordance with the Oxford Health Plans Contract. I authorize my employer to deduct from my wages the amount required (if any) to cover my contribution for coverage. I certify that I and any of my dependents have no other dental insurance other than that listed above. I certify that all the above information is correct.

X

EMPLOYEE SIGNATURE DATE

Oxford Health Plans (NJ), Inc./Oxford Health Insurance, Inc.

Temporary HINT Supplemental Enrollment Information Form Implementing P.L. 2005, c. 375

A. Group & Employee Information

Group Name: _____

Group Number: _____

Employee Name: _____

Employee ID Number: _____

B. Type of Activity (see Important Explanatory Information below)

Date of Event

____/_____/_____

____/_____/_____

____/_____/_____

Change-Check all that apply

☐ Add dependent over the limiting age, but less than 30

☐ Remove dependent over the limiting age, but less than 30

Reasons:

_____

_____

Continuation of Coverage pursuant to P.L. 2005, c. 375

Coverage is being effected:

☐ During an Open Enrollment

☐ Within 30 days prior to attainment of limiting age

☐ Within 30 days after eligibility for other reasons

☐ During special 12-month enrollment

C. Over-age Dependent Information

Name (last, first, MI) _____ Sex: ☐ M ☐ F

Address _____

City _____ST _____ Zip _____

Birthdate: (MM, DD, YY) ____/____/____ SSN: _____

Other Health Coverage: ☐ Yes ☐ No Other Rx Drug Coverage: ☐ Yes ☐ No

Primary Office ID Number: _____Current Patient: ☐ Yes ☐ No

Ob/Gyn Office ID Number:_____Current Patient: ☐ Yes ☐ No ☐ N/A

Previous Coverage: ☐ Yes ☐ No

If yes, provide the following information AND submit a copy of the certificate of Creditable Coverage that was issued by the previous carrier, if available:

Effective date of prior coverage: ___/___/___
Termination date of prior coverage: ___/___/___
Name of prior carrier: _____
Prior plan number: _____

Important Information Regarding Your Plan

As permitted by law, Oxford has chosen to administer the over-age dependent coverage as a "stand-alone" plan. This means that charges incurred by the over-age dependent are separated from those charges incurred by other members of the family covered on the policy. The over-age dependent's charges do not apply toward meeting the family deductible, out-of-pocket maximum or other cost-sharing requirements or limitations applicable to the other family members as a unit. Instead, the over-age dependent's covered charges are applied towards meeting a deductible, out-of-pocket maximum or other cost-sharing requirements and limitations as if the over-age dependent had single coverage under the group plan.

D. Signature

_____ _____

Employee Dependent

_____ _____

Date Date

IMPORTANT EXPLANATORY INFORMATION

An adult child may request to continue as a dependent on his or her parent's coverage even after the child reaches the limiting age under the terms of the policy if the adult child:

- is not yet 30 years old
- is unmarried
- has no children
- lives in New Jersey or, if not a New Jersey resident, is a full-time student at an accredited institution of higher education
- is not eligible for Medicare and is not actually covered under another group or individual health plan.

An adult child may make the request to continue as a dependent on his or her parent's coverage either:

- when he or she first reaches the limiting age
- when he or she first becomes eligible for a reason other that reaching the limiting age (for example, the adult child becomes a full-time student in another state, or returns to live in New Jersey after residing elsewhere), or
- during the open enrollment period for the group of which the parent is a member.

In addition, adult children who reached the limiting age under the parent's coverage prior to May 12, 2006 may make an enrollment request at any time from May 12, 2006 through May 11, 2007.

The adult child or covered employee may be required to pay up to 102% of the cost of the dependent premium.