Oxford

Connecticut Small Group Blue Ribbon Application

Oxford Health Insurance, Inc.

Mailing Address: P.O. Box 7085, Bridgeport, CT 06601-7085 •800-889-7658•*www.oxfordhealth.com*

I. GENERAL INFORMATION

1. Full legal name of company:

2. Address of company:

(Street Address
City, State, Zip Code **Please - Do not use a PO Box.)*

3. Benefit 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. E-mail Address

4. Person to receive correspondence/billing statements:

a. Name:

b. Title:

c. Address:
(Street Address
City, State, Zip Code)

d. Phone Number:
Area Code

5. Start Date of Business:

6. Name and Address of Parent Company:

a. Name:

b. Address:

7. Full legal name and address of each subsidiary, affiliated company, branch or satellite office whose employees are to be covered:

8. Nature of business:

9. SIC Code filed with the State of CT:

10. Type of Organization: ❒ Corporation ❒ Partnership ❒ Proprietorship ❒ LLC ❒ Other ___________

Federal I.D. ______________ State Tax I.D. ______________

11. Is your group subject to:

a. COBRA (20+ lives)? ❒ Yes ❒ No

b. State Continuation (<20 lives)? ❒ Yes ❒ No

12. Did your group employ no more than 50 employees for at least 50% of your business days during the preceding 12 months? ❒ Yes ❒ No

II. ADMINISTRATIVE INFORMATION

The term "coverage" means the benefits provided by Oxford, pursuant to the Group Certificate.

1. Effective date: We request that this coverage be effective as of the first day of ______________________________.
(Month/Year)

2. Anniversary date: The anniversary date will fall annually on the first day of the calendar month of the approved effective date.

3. Other group health or individual coverage: Indicate below other coverage which is still in force or that which has terminated within the past three (3) years.

* Please Note: Do not cancel existing coverage until you have received acceptance of this coverage by Underwriting.

* If no previous coverage, initial here _________.

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

4. Employer Contributions: Toward Employee Premium:________________%

Toward Family Premium:________________%

5. Eligibility and Termination: Each employee must be eligible on the date the insurance provided under the Certificate becomes effective with respect to him/her. If the employee is not eligible for coverage on the date the Certificate becomes effective, the employee must wait until he/she is eligible.

a) Defining Eligible Employees:

Active Employees: All active, eligible, full-time employees who work at least _______ hours per week, including business owners and principals (minimum 30 hours/week).

Defining Eligible Employees (continued)

Retired Employees: ❑ Covered ❑ Not Covered

The definition of a Retired Employee is:

- ❑ an employee who is retired and on pension by the employer.
- ❑ an employee who is retired and 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 (select one Eligibility option and one Termination option).

CLASS I

Definition of Class I ____

____

i) Eligibility

❑ Date on which the employee completes:

*_________ months of continuous service, or

*_________ days of continuous service.

❑ On the first day of the calendar month coinciding with or next following the date on which the employee completes:

*_________ months of continuous service, or

*_________ days of continuous service.

*** 6 months maximum**

ii) Termination

❑ On the last day of the calendar month in which employee's employment terminates.

❑ Date of termination of employment.

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

CLASS II

Definition of Class II ____

____

i) Eligibility

❑ Date on which the employee completes:

*_________ months of continuous service, or

*_________ days of continuous service.

❑ On the first day of the calendar month coinciding with or next following the date on which the employee completes:

*_________ months of continuous service, or

*_________ days of continuous service.

*** 6 months maximum**

ii) Termination

❑ On the last day of the calendar month in which employee's employment terminates.

❑ Date of termination of employment.

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

6. Number of Active Employees as of the Effective Date: Total employees ______

Of the Total employees: How many are active eligible full-time employees who work in CT? ______

How many are part-time or temporary employees? ______

How many are retired employees? ______

7. Are there any employees or dependents of employees who are covered under COBRA or State Continuation on your current plan? ❒ Yes ❒ No

8. Are there any employees or 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? ____________________

- *If you answered "Yes" to either question 7 or 8 above, please complete the information below.*

Question 7 or 8	Date of Qualifying Event	Name of Employee, Dependent or COBRA Continuant	Reason

9. 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.

10. 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.

11. Dependent Eligibility: Dependents are defined as follows:
    - a legal spouse
    - any child (natural, adopted, placed for adoption, or step child) of the insured or insured's spouse who is under the age of 26 and who:
      - is not married; or
      - is a resident of the state (this does not apply to children under 19 years of age or full-time students)

    Coverage for dependent children will end on the last day of the month following the month in which the child:
    - marries; or
    - becomes covered under a group health plan through the child's own employment; or
    - ceases to be a resident of Connecticut (this does not apply to children under the age of 19 or full-time students)

    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 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.

12. Plan Exclusions and Limitations: Please refer to your Group Certificate for a complete list of exclusions and limitations.

III. BLUE RIBBON PLAN DESIGN

Gated PPO includes:

In-Network:

1. Standard Deductible	$500
2. Coinsurance	10%
3. Inpatient Facility Deductible	$500
4. Skilled Nursing Facility Deductible	$500
5. Emergency Room (Standard Deductible applies)	$500
6. Durable Medical Equipment Deductible (Standard Deductible applies)	$500
7. Prosthesis Deductible (Standard Deductible applies)	$500
8. Pharmacy (includes Contraceptives) (Standard Deductible applies)	$500

Out-of-Network:

1. Standard Deductible	$500
2. Coinsurance	20%
3. Inpatient Facility Deductible	$500
4. Skilled Nursing Facility Deductible	$500
5. Emergency Room (Standard Deductible applies)	$500
6. Durable Medical Equipment Deductible (Standard Deductible applies)	$500
7. Prosthesis Deductible (Standard Deductible applies)	$500
8. Pharmacy (includes Contraceptives)	$500

Maximums and Limitations

1. Pharmacy (includes Contraceptives)	$5 Copay
2. Physical Therapy Limit	30 visits per prescribed course of treatment (In- and Out-of-Network)
3. Dependent age cutoff	19/26
4. Out of Pocket for Covered Services	$1,500 single/ $3,000 family (In- and Out-of-Network)

Medicare Part D 28% Subsidy - for Rx plan design above, do you currently participate or plan to participate with the 28% Government Subsidy for your Medicare eligible retirees?

❐ Yes ❐ No

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 Applicant

____

Signature of Authorized Officer of Applicant | Title of Officer of Applicant | Date

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:			

***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.

V. COBRA & EXTENSION OF BENEFITS DATA

1. Are there any employees or dependents of employees who are covered under COBRA or State Continuation on your current plan? ❒ **Yes** ❒ **No**

If yes, identify the number of individuals ________________

2. Are there any employees or 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. 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 acknowledges that the Effective Date of Coverage is not guaranteed and is subject to receipt by Oxford of full requirements including completed Family Health Statements for all employees and their dependents enrolling for 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, 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.

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 ______________________ X ______________________

Witness

Duly Licensed Resident Agent/Broker

UnitedHealthcare
Oxford

Connecticut Small Group Attachment A-OHP

Oxford Health Plans (CT), Inc.

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

UNDERWRITING GUIDELINES

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

A. The Employer confirms that of the employees eligible to be insured on the effective date by Oxford, no more than 49% live outside Oxford's service area.

B. **Participation Requirements:**

- The Employer confirms Employer groups of 2-9 lives (of the eligible employees to be insured on the effecttive date by Oxford) must have 75% of eligible employees enroll onto the health plan.*
- Employer groups of 10-50 lives (of the eligible employees to be insured on the effective date by Oxford) must have 65% of eligible employees enroll onto the health plan. *

C. The Employer confirms that the Applicant has been registered with a Connecticut State Tax ID number for three consecutive months prior to the effective date, the Applicant has not been in bankruptcy or reorganization, and is currently in full compliance with all loan agreements and credit facilities which the Applicant is a party to.

D. The Employer confirms that it will always contribute at least 50% of the total premium for all employee health coverage.

E. The Employer confirms that the deposit equals one month's premium.

* All ineligible employees and employees that are waiving coverage due to spousal coverage (signed waivers required) are subtracted from the total number of employees when determining participation requirements.

Connecticut Legislation on Premium Payments for Terminated Employees

We want you to be aware of important State of Connecticut legislation regarding health insurance premium payments for terminated employees.

Effective October 1, 2009, Connecticut Public Act No. 09-126 provides employers (with fully insured health plans) an election to terminate an employee's medical insurance coverage under a group health insurance policy 72 hours after termination of employment, for any reason other than layoff or if an employee voluntarily terminates employment.

If the employer chooses to terminate the policy and wants to receive a premium credit, it is the employer's responsibility to e-mail or fax an **Employer Request for Premium Credit form** to us no later than 72 hours after the termination. The e-mail address and fax number are included on the form. **The form will not be accepted by mail.**

It is also the employer's responsibility to notify the former employee of this election within 72 hours of termination and to remit to the former employee, his or her share of any credited or returned premium.

The Employer Request for Premium Credit form is enclosed and available through the Employers site at *www.oxfordhealth.com*. Once you log in, choose the *Tools & Resources* tab. Under *Practical Resources*, select *Your Benefit Coverage*, and then *Forms*. The Employer Request for Premium form will be listed with Connecticut small and large group information.

If you have any questions regarding this Public Act, please contact your Oxford representative.

Employer Request for Premium Credit

Please complete and **e-mail or fax** this form to us **within 72 hours** of the employee's termination date. **This form will not be accepted by mail.**

E-mail: *groupservices@oxfordhealth.com*
Fax: 1-888-454-0386 *(for large groups of 51+)*

If this form is received after the 72 hours, the group will not be eligible for a premium credit.

Effective October 1, 2009, Connecticut Public Act No. 09-126 provides employers (with fully insured health plans) an election to terminate an employee's medical insurance coverage under a group health insurance policy 72 hours (3 calendar days) after termination of employment. The law applies to an employee who:

- Voluntarily terminates employment **or**
- Is terminated for any reason other than layoff, or relocation or closing of a covered establishment

If the employer elects to request a credit of the employee's (and dependents) pre-paid premium, this form must be completed and e-mailed or faxed within 72 hours of the employee's termination date. **If this form is received after the 72-hour period, the credit request will not be processed.**

Please print the following information:
Group Name:
Group ID Number:
Member Name:
Member ID:
Employee Termination Date:
Employee Termination Reason:
Benefits Administrator Name:
Signature of Benefits Administrator:
Date Signed:

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