UnitedHealthcare®
Oxford

Freedom Plan®
Freedom Plan® Select℠
HMO Laurel℠
HMO Laurel Select℠
Freedom Plan® Laurel℠
Freedom Plan® Laurel Select℠
HMO/Freedom
HMO Select
CT Blue Ribbon
HMO Deductible Plan

Connecticut Small Group Application-OHP

Oxford Health Plans (CT), Inc.

Mailing Address: 14 Central Park Drive, Hooksett, NH 03106 • *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. 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. E-mail 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 and 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:

8. Nature of business:

9. SIC Code filed with the State of CT:

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

11. Tax Identification Code or Number:

    a. Federal I.D.

    b. State Tax I.D.

12. **Is your group subject to:**

    a. COBRA (20+ lives)? ❒ **Yes** ❒ **No**

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

13. **Did your group employ at least 1 but 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" refers to 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.

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 for coverage.

a) Employee Eligibility :

Full-time Employees: ❑ Please check here to confirm that all permanent full-time employees work a minimum 30 hours/week (20-29 hours if elected by the Group). Also, if the minimum hours are more than the required hours, please enter the hours per week here _____.

UnitedHealthcare

OXFORD

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:

© 2010 Oxford Health Plans LLC. Oxford HMO products are underwritten by Oxford Health Plans (NY), Inc., Oxford Health Plans (NJ), Inc. and Oxford Health Plans (CT), Inc. Oxford insurance products are underwritten by Oxford Health Insurance, Inc.

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.

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

UnitedHealthcare Oxford

FAMILY HEALTH STATEMENT

CHECK ONE: New Group ☐ New Employee Add ☐ Existing Employee Change ☐

PRINT IN INK----COMPLETE BOTH SIDES OF FORM

TO BE COMPLETED BY EMPLOYER

NAME OF EMPLOYER:	EMPLOYER ADDRESS: Street:
POLICY NUMBER	City: ST/Zip:

APPLICANT'S OCCUPATION	HOURS WORKED/WEEK	DATE OF FULL TIME HIRE

TO DECLINE COVERAGE -- EMPLOYEE IS TO COMPLETE THIS AREA

( ) I **DECLINE** TO ENROLL FOR HEALTH COVERAGE DUE TO THE EXISTENCE OF OTHER GROUP HEALTH COVERAGE
FOR: MYSELF ( ) SPOUSE ( ) DEPENDENT CHILDREN ( )

If I and/or my dependents decline coverage and desire to participate in the plan at a later date, **I may** have to submit evidence of insurability satisfactory to the insurance company.

SIGNATURE OF EMPLOYEE: **DATE:**

TO REQUEST COVERAGE--ANSWER ALL QUESTIONS

IF ADDITIONAL SPACE IS NEEDED, ATTACH SEPARATE SHEET -- COMPLETE FOR ALL FAMILY MEMBERS APPLYING FOR COVERAGE

FIRST NAME INITIAL LAST NAME	HEIGHT	WEIGHT	DATE OF BIRTH MM/DD/YYYY	SEX M/F	FULL TIME STUDENT Yes/No--If yes, Name School
EMPLOYEE:					
SPOUSE:					

EMPLOYEE SOCIAL SECURITY NUMBER:	MARITAL STATUS: ( ) SINGLE ( ) MARRIED
EMPLOYEE ADDRESS: Street:	PHONE: WORK ( ) - HOME ( ) -
City: ST/Zip:	WHERE WOULD YOU PREFER TO BE CALLED DURING THE DAY? ( ) HOME ( ) WORK

I hereby represent and agree that all the answers and statements in this request are full, complete and true, to the best of my knowledge and belief and understand that the said answers and statements form the basis upon which insurance will be made effective. I understand that omissions, misrepresentations, or misstatements about medical history could result in the denial of an otherwise valid claim and rescission, voiding, or reformation of insurance.

DATE:_____ Employee Signature: _____ Spouse Signature:_____

OTHER SIDE MUST BE COMPLETED

EMPLOYER NAME:_____

(please print)

- ARE YOU NOW ACTIVELY AT WORK FULL TIME (PER EMPLOYER DEFINITION)? ( ) YES ( ) NO
- DOES YOUR SPOUSE HAVE MEDICAL COVERAGE ELSEWHERE? ( ) YES ( ) NO
- IS ANY PERSON TO BE INSURED CURRENTLY COVERED UNDER COBRA? ( ) YES ( ) NO
- IS ANY PERSON TO BE INSURED ENROLLED IN MEDICARE? ( ) YES ( ) NO

IF YES, WHO:_____ ( ) MEDICARE A ( ) MEDICARE B

TO REQUEST COVERAGE--ANSWER ALL QUESTIONS **DETAILS MAY BE SUBMITTED VIA SEALED ENVELOPE MARKED "CONFIDENTIAL"**

FOR "YES" ANSWERS, DETAILS MUST BE PROVIDED *IF ILLNESS IS UNLISTED, PROVIDE DETAILS IN THE ROW MARKED "OTHER"*

	YES	NO
1. Are you, your spouse, or any dependent to be insured, currently disabled or unable to perform their normal activities? WHO: WHY:		
2. Have you, or any dependent, been hospitalized, or been advised to be hospitalized within the past 5 years for any reason? WHO: WHY:		
3. Have you, or any dependent, had surgery, or been advised to have surgery within the past 5 years for any reason? WHO: WHY:		
4. Are you, or any dependents to be covered, currently pregnant? WHO: EXPECTED DELIVERY DATE		
5. Is this pregnancy the result of infertility treatment? Please explain:		
6. Are you, or any dependents to be covered, currently taking any medication? WHO: _____ MEDICATION:_____ WHY:_____		
7. Have you, or any dependent, had medical expenses in excess of $5,000.00 in the last 12 months? WHO: WHY:		

8. Have you, or any dependent ever had, or has a Medical Professional told, counseled, or treated, you or any dependent, for any of the following?

	YES	NO	Person Affected	Diagnosis & Date Diagnosed	Treatment And/or Medication	Degree of Recovery	Name, Address & Phone Number of Physician and/or Hospital
a) Chest Pain, Heart Attack, or other heart condition							
b) Condition/Disease of the circulatory system (i.e. blood vessels, phlebitis, leg ulcers)							
c) Cancer, tumor, or lymph node enlargement (indicate type of cancer and location)							
d) Acquired Immuno Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)							
e) High Blood Pressure (if yes, provide most recent reading)							
f) Diabetes or disorder of endocrine system or glands (indicate if insulin dependent)							
g) Alcohol or drug use, abuse, and/or dependency							
h) Disease of the kidney, bladder or urinary tract							
i) Crohns, Colitis, diseases of stomach, intestine, esophagus or gallbladder							
j) Disorder of the liver or pancreas							
k) Disorder of the lungs or respiratory system							
l) Organ Transplants (if yes, include type and date)							
m) Neurologic problems--disorder of the brain, seizures, epilepsy, central nervous system--stroke or paralysis							
n) Nervous, mental, depression, stress or anxiety related disorder, eating disorder							
o) Disorder of the blood (including anemia)							
p) Lupus or Arthritis (if yes, indicate type and severity of disability)							
q) Congenital anomalies or disorders							
r) OTHER (any disease/condition not listed above)							

UnitedHealthcare®
Oxford

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

Connecticut Health Benefits Waiver of Coverage

Local Address: 48 Monroe Turnpike, Trumbull, CT 06611 ▪ 800-889-7658 ▪ *www.oxfordhealth.com*

Group Name: _____

Policyholder Name: _____

Employee Name: _____
Last First Middle Initial

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 (CT), Inc. / Oxford Health Insurance, Inc. I refuse coverage:

Reason for Refusal (Please check all appropriate boxes.)

- ❑ other group coverage sponsored by my employer
- ❑ other group coverage sponsored by my spouse's employer
- ❑ other group coverage sponsored by another organization
- ❑ other reasons (please explain)

Please provide name of carrier and policy number: _____

_____
Signature of Employee Date

_____
Signature of Benefits Administrator Date

Connecticut 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, EACH FIELD MUST BE COMPLETED ACCURATELY AND IN ITS ENTIRETY.

BE SURE TO:

- Use only black or blue 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)
- Complete the "Family Health Statement," if required
- Attach disability paperwork, if applicable
- Submit this form within 31 days of the requested effective date or within 60 days of the qualifying event for COBRA or State Continuation (SC)

In answering these questions, you should not include any genetic information. Please do not include any family medical history information or any information related to genetic services or genetic diseases for which you believe you may be at risk.

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

1-800-444-6222.

Connecticut Member Enrollment Form – OHP

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

UnitedHealthcare Oxford

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

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

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

☐ Actively at Work - Hours Per Week _____ ☐ Retired ☐ On Leave of Absence ☐ Union Employee ☐ 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:		☐ Civil Union ☐ Domestic Partner ☐ Actively Working		

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: Policyholder: Group Number:	BIN: PCN:	BIN: PCN:	BIN: PCN:	BIN: PCN:
Medical ☐ Same for all	Policy Number: Carrier: Policyholder: Effective Date:	/ /	/ /	/ /	/ /

I authorize deductions from my earnings for any required contributions. I will discuss any questions that I have about the plan with the Oxford Customer Service Department. My signature below affirms eligibility for coverage, and that all information provided is full, complete and true to the best of my knowledge. 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 subjects such person to criminal and civil penalties. 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, covered services will be treated as out-of-network benefits under the terms and conditions outlined in the Certificate.

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

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.

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

*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)

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)

6. **Number of Total Employees the Effective Date:**

   Full-time Employees _____ Part-time Employees _____ Retired Employees _____

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

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.

9. **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

   Coverage for dependent children will end on the last day of the month following the month in which the child no longer meets dependent eligibilty requirements.

   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.

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

III. PRODUCT/PLAN DESIGN

SECTION 1: UnitedHealthcare Benchmark Solutions Oxford suite of products: Freedom Plan and Freedom Plan Select

1. Please select a plan type and plan number (if applicable):

   ❑ Freedom Plan ❑ Freedom Plan Select

   (Deductibles and Out-of-pocket Accumulation Periods are on a Calendar Year basis.)

Options	❑ Plan 4	❑ Plan 6
Copayment	$15	$20
Single Deductible	$1,000	$1,000
Family Deductible	$2,500	$2,500
Coinsurance	70%	70%
Coinsurance Maximum	$10,000	$10,000

2. **Please select a Prescription rider and desired coverages:**

Pharmacy benefit: (Tier 1/ Tier 2/ Tier 3 Copayment)

❒ $10/$20/$35 ❒ $15/$25/$40 ❒ $15/50% ❒ None

Deductible Options: For 3 tier plans, the deductible applies to Tier 2 and Tier 3 drugs. For 2 tier plans, the deductible is waived for generics.

❒ None ❒ $50 ❒ $100 ❒ $200

Contraceptives:

❒ Yes (Standard) ❒ No (Qualified State Exempt Groups Only)

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

3. **Additional Benefit Information**

❒ Vision ❒ Prosthetics
❒ Dental Plan Premium ❒ Dental Plan Enhanced
Outpatient Physical Therapy: ❒ 60 Visits ❒ 90 Visits (Standard)
Inpatient Hospital Copayment: ❒ None (Standard) ❒ $250 ❒ $500
Emergency Room: ❒ $25 ❒ $35 ❒ $50 (Standard) ❒ $75 ❒ $100

❒ Other: _____

SUBJECT TO HOME OFFICE APPROVAL

SECTION 2: UnitedHealthcare Benchmark Solutions Oxford suite of products: HMO Laurel, HMO Laurel Select, and Freedom Plan Laurel Select

1. **Please select a plan type and a plan design:**

❑ HMO Laurel ❑ HMO Laurel Select

(Deductibles and Out-of-Pocket Accumulation Periods are on a Calendar Year basis.)

Options:	❒ A.	❒ E.	❒ F.
Plan Type:	HMO	HMO	HMO
Office Copayment (PCP/Specialist):	$30/$45	$15/$25	$25/$40
Single/Family Deductible:	N/A	N/A	N/A
Coinsurance:	N/A	N/A	N/A
Hospital Copayment: (up to $2,000/calendar year)	$500/day	$100/continuous confinement	$250/day
Outpatient Surgery Copayment:	$250	$50	$100
Emergency Room Copayment:	$150	$75	$100

For prescription and additional riders please see the following page.

❑ Freedom Plan Laurel Select

(Deductibles and Out-of-pocket Accumulation Periods are on a Calendar Year basis.)

Options:	❒ B.	❒ C.	❒ D.
Plan Type:	POS	POS	POS
Office Copayment (PCP/Specialist):	$15/$25	$25/$40	$30/$45
Out-of-network Deductibles:			
Single:	$1,000	$1,000	$2,500
Family:	$3,000	$3,000	$7,500
Out-of-network Coinsurance:	70%	70%	70%
Single Coinsurance Maximum:	$10,000	$15,000	$20,000
In-network Hospital Copayment:	$100 per admission (up to $2,000 per calendar year)	$250 per day (up to $2,000 per calendar year)	$500 per day (up to $2,000 per calendar year)
Outpatient Surgery Copayment:	$50	$100	$250
Emergency Room Copayment:	$75	$100	$150

2. Please select a Prescription rider and desired coverages:

Pharmacy benefit: (Tier 1/ Tier 2/ Tier 3 Copayment)

❒ $10/$20/$35 ❒ $15/$25/$40 ❒ $15/50%

❒ None

Deductible options For 3 tier plans, the deductible applies to Tier 2 and Tier 3 drugs. For 2 tier plans, the deductible is waived for generics.

❒ None ❒ $50 ❒ $100 ❒ $200

Contraceptives:

❒ Yes (Standard)

❒ No (Qualified State Exempt Groups Only)

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

3. Additional Benefit Information

❒ Vision

❒ Dental Plan Premium ❒ Dental Plan Enhanced

Outpatient Physical Therapy ❒ 60 Visits (Standard) ❒ 90 Visits

Skilled Nursing Facility ❒ 30 Visits (Standard) ❒ Unlimited

❒ Other: _____

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SECTION 3: Freedom Plan, Freedom Plan Select, HMO, HMO Select, CT Blue Ribbon, and HMO Deductible Plan

1. Please select a plan type and plan number (if applicable):

❑ Freedom Plan ❑ Freedom Plan Select

(Deductibles and Out-of-Pocket Accumulation Periods are on a Calendar Year basis.)

Options:	❒ Plan 1	❒ Plan 2	❒ Plan 3	❒ Plan 4	❒ Plan 5	❒ Plan 6
Office copayment:	$10	$10	$15	$15	$15	$20
Single deductible:	$250	$500	$300	$1,000	$500	$1,000
Family deductible:	$625	$1,250	$750	$2,500	$1,250	$2,500
Coinsurance:	80%	70%	80%	70%	70%	70%
Single coinsurance maximum:	$5,000	$10,000	$5,000	$10,000	$10,000	$10,000

❑ HMO ❑ HMO Select

Options:	❒ Plan 7	❒ Plan 8	❒ Plan 9	❒ Plan 10
Office copayment:	$5	$10	$15	$20

❑ CT Blue Ribbon Plan Design

1.	Office copayment	$10
2.	Inpatient Facility copayment	$500 Per Admission not to exceed 50% of the charge for the services provided
3.	Skilled Nursing Facility copayment	$500 Per Admission not to exceed 50% of the charge for the services provided
4.	Emergency Room copayment	$25
5.	Durable Medical Equipment copayment	$400 Per Item
6.	Prosthesis copayment	$400 Per Item, waived for internal prosthesis
7.	Physical Therapy limit	30 Visits per prescribed course of treatment
8.	Pharmacy (Includes Contraceptives)	
	a. Generic/Brand copayment	$5
	b. Limit	$1,000
9.	Dependent age cutoff	19/26
10.	Out-of-pocket for covered services	$1,500 single / $3,000 family

2. Please select a Prescription rider and desired coverages:
Please Note : If CT Blue Ribbon Plan Design was selected, the following options are not available.

Pharmacy benefit: (Tier 1/ Tier 2/ Tier 3 Copayment)

❒ $5/$10 ❒ $5/$15 ❒ $7/$20
❒ $5/$10/$25 ❒ $5/$15/$35 ❒ $7/$15/$35
❒ $10/$20/$35 ❒ $15/50% ❒ None

Deductible Options: For 3 tier plans, the deductible applies to Tier 2 and Tier 3 drugs. For 2 tier plans, the deductible is waived for generics.
❒ None ❒ $50

Contraceptives:
❒ Yes (Standard) ❒ No (Qualified State Exempt Groups Only)

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

3. Additional Benefit Information
Please Note: If CT Blue Ribbon Plan Design was selected, the following options are not available.

❒ Vision ❒ Prosthetics
❒ Dental Plan Premium ❒ Dental Plan Enhanced
Outpatient Physical Therapy: ❒ 60 Visits ❒ 90 Visits (Standard)
Inpatient Hospital Copayment: ❒ None (Standard) ❒ $250 ❒ $500
Emergency Room: ❒ $25 ❒ $35 ❒ $50 (Standard) ❒ $75 ❒ $100

❒ Other: _____

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❑ HMO with deductible option:

HMO, Freedom, Non-Gated
(Deductibles and Out-of-Pocket Accumulation Periods are on a ❒ Calendar Year basis ❒ Contract Year basis)

Options:	❒ Plan A	❒ Plan B
Office copayment (PCP/Specialist)	$20/$40	$30/$45
Deductible	$1500	$2500
Coinsurance	100%	100%
Inpatient hospital copayment	Deductible & coinsurance	Deductible & coinsurance
Outpatient surgery copayment	Deductible & coinsurance	Deductible & coinsurance
Emergency room copayment	$150	$150

Available RX Plans

Options:	❒ RX Plan 1	❒ RX Plan 2	❒ RX Plan 3	❒ RX Plan 4	❒ RX Plan 5
Tier 1	$7	$7	$15	$10	$15
Tier 2	$20	$15	$25	$20	50%
Tier 3	N/A	$35	$40	$35	50%
Annual Max	None	None	None	None	None
Deductible Option	❒ $0 ❒ $50 Deductible applies to Tier 2 & 3 only	❒ $0 ❒ $50 Deductible applies to Tier 2 & 3 only	❒ $0 ❒ $50 ❒ $100 ❒ $200 Deductible applies to Tier 2 & 3 only	❒ $0 ❒ $50 ❒ $100 ❒ $200 Deductible applies to Tier 2 & 3 only	❒ $0 ❒ $50 ❒ $100 ❒ $200 Deductible applies to Tier 2 & 3 only

Contraceptives: ❒ Yes (standard) ❒ No (Qualified State Exempt Groups Only)

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

Available Riders

❒ Vision
❒ Dental Plan Premium
❒ Dental Plan Enhanced
❒ Unlimited Durable Medical Equipment
Outpatient Physical Therapy 90 Visits ❒ 60 Visits (Standard) ❒ 90 Visits
Skilled Nursing Facility ❒ 30 Visits (Standard) ❒ Unlimited

SECTION 4: HMO Laurel, HMO Laurel Select, Freedom Plan Laurel, and Freedom Plan Laurel Select

1. Please select a plan type and a plan design:

❑ HMO Laurel ❑ HMO Laurel Select

(Deductibles and Out-of-Pocket Accumulation Periods are on a Calendar Year basis.)

Options:	❒ A.	❒ E.	❒ F.
Plan Type:	HMO	HMO	HMO
Office Copayment (PCP/Specialist):	$30/$45	$15/$25	$25/$40
Single/Family Deductible:	N/A	N/A	N/A
Coinsurance:	N/A	N/A	N/A
Hospital Copayment: (up to $2,000/calendar year)	$500/day	$100/continuous confinement	$250/day
Outpatient Surgery Copayment:	$250	$50	$100
Emergency Room Copayment:	$150	$75	$100

For prescription and additional riders please see the following page.

❑ Freedom Plan Laurel ❑ Freedom Plan Laurel Select

(Deductibles and Out-of-pocket Accumulation Periods are on a Calendar Year basis.)

Options:	❒ B.	❒ C.	❒ D.
Plan Type:	POS	POS	POS
Office Copayment (PCP/Specialist):	$15/$25	$25/$40	$30/$45
Out-of-network Deductibles:			
Single:	$1,000	$1,000	$2,500
Family:	$3,000	$3,000	$7,500
Out-of-network Coinsurance:	70%	70%	70%
Single Coinsurance Maximum:	$10,000	$15,000	$20,000
In-network Hospital Copayment:	$100 per admission (up to $2,000 per calendar year)	$250 per day (up to $2,000 per calendar year)	$500 per day (up to $2,000 per calendar year)
Outpatient Surgery Copayment:	$50	$100	$250
Emergency Room Copayment:	$75	$100	$150

For prescription and additional riders please see the following page.

2. **Please select a Prescription rider and desired coverages:**

Pharmacy benefit: (Tier 1/ Tier 2/ Tier 3 Copayment)

❒ $10/$20/$40 ❒ 50% (excludes mail order) ❒ $15/50%

❒ None

Deductible options For 3 tier plans, the deductible applies to Tier 2 and Tier 3 drugs. For 2 tier plans, the deductible is waived for generics.

❒ None ❒ $50

Contraceptives:

❒ Yes (Standard)

❒ No (Qualified State Exempt Groups Only)

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

3. **Additional Benefit Information**

❒ Vision

❒ Dental Plan Premium ❒ Dental Plan Enhanced

Outpatient Physical Therapy ❒ 60 Visits (Standard) ❒ 90 Visits

Skilled Nursing Facility ❒ 30 Visits (Standard) ❒ Unlimited

❒ Other: _____

_____

SUBJECT TO HOME OFFICE APPROVAL

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. 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. 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.

VII. 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

Witness

X

Duly Licensed and Appointed Producer*

***Please note: If you are not currently appointed by Oxford in CT, you must contact Oxford's Commissions Department at 1-888-666-6844 in advance of executing this application.**