UnitedHealthcare
Oxford

Freedom Plan® Classic℠
Freedom Plan® Access℠
Freedom Plan® Direct℠
Freedom Plan® Value Option℠
Oxford MyPlan℠
Oxford® HSA Direct℠
Oxford USA℠

# Connecticut Large Group Application-OHI

Oxford Health Insurance, Inc.

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

## I. GENERAL INFORMATION

1. **Full Legal Name of Firm:**

2. **Address of firm:**
(Street Address
City, State, Zip Code
Do not use a P.O. Box.)

3. **Plan Administrator/Contact:**
   a. Name and Title:
   b. Address:
   (If different from address of firm)
   (Street Address
   City, State, Zip Code
   Do not use a P.O. Box.)
   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 (if different from above):**
   a. Name:
   b. Title:
   c. Address:
   (Street Address
   City, State, Zip Code)
   d. Phone Number: Area Code
   e. Fax Number: Area Code

5. **Start Date of Business:**

6. **Full Legal Name & Address of Parent Company:**
   a. Name:
   b. Address:
   (Street Address
   City, State, Zip Code)

7. **Full Legal Name & Address of Each Subsidiary and/or Affiliated Company, Branch or Satellite Office whose Employees are to be Covered:**
   a. Name:
   b. Address:
   (Street Address
   City, State, Zip Code)

8. **Nature of Business:**

9. **SIC Code:** ______________________________

10. **Tax Identification Code or Number:**

a. Federal I.D. ______________________________

## II. ADMINISTRATIVE INFORMATION

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

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 that is still in force or that 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: __________%

***Please note:*** **Employer contribution must be at least 50% toward employee premium.**

5. **Eligibility and Termination:** Each employee must be eligible on the date the insurance provided under the Certificate of Coverage becomes effective with respect to him/her. If the employee is not eligible for coverage on the date the Certificate of Coverage 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. Also, if the minimum hours are more than the required 30 hours, please enter the hours per week here _________.

Are any classes excluded? ❑ Yes ❑ No

If yes, indicate classes excluded: ______________________________

***Part-Time Employees:*** ❑ Yes, part-time employees who work at least _____ hours per week (minimum of 20 hours/week) ❑ Not covered

***Retired Employees:*** ❑ Covered ❑ Not covered

The definition of a retired employee is:

- ❑ an employee who is retired on pension by the employer
- ❑ an employee who is retired on pension by the employer and who immediately prior to the date of retirement had completed at least _____ years of service with the employer
- ❑ an employee who is retired from service by the employer and who immediately prior to the date of retirement had completed at least _____ years of service with the employer

b) **Eligibility and 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 the first day of the calendar month coinciding with or following the date that the employee completes the group specified length of continuous service.

## CLASS I

**Definition of Class I** ____________________________________________

____________________________________________

**i) Eligibility**

❑ Date that 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 following the date that the employee completes:

*_________ month(s) of continuous service, or

*_________ days of continuous service

**Termination**

❑ On the last day of the calendar month in which the 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**

## CLASS II

**Definition of Class II** ____________________________________________

____________________________________________

**i) Eligibility**

❑ Date that 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 following the date that the employee completes:

*_________ month(s) of continuous service, or

*_________ days of continuous service

**Termination**

❑ On the last day of the calendar month in which the 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**

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

7. **Coordination of Benefits:** To the extent permitted by law, all health expense benefits will be coordinated with benefits under any No-Fault Auto Plan, under any other Group Plan, and under any Group-Type Plan.

8. **Integration with Medicare Benefits:** Health Benefits will be integrated with Medicare Benefits for retired employees age 65 or over and their dependents age 65 or over if the group offers retiree coverage.

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 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.

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

## III. PRODUCT/PLAN DESIGN

**Please select from Sections 1, 2, 3, 4, or 5 for in-area employees .**
**Please select from Section 6 (Oxford USA) for out-of-area employees.**

### SECTION 1: Freedom Plan Classic (Gated) & Freedom Plan Access (Non-Gated)

1. **Conversion Status:** ❑ Full Conversion ❑ Offering
2. **Product:** ❑ Freedom Plan Classic ❑ Freedom Plan Access

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

3. **Please complete section below:**
   Office Copayment ______________
   Deductible ______________
   Family Multiple ______________
   Coinsurane ______________
   Coinsurance Maximum (%) ______________

   Out-of-network Reimbursement:
   ______ UCR Fee schedule [1]
   ______ Medicare rate [2]

4. **Please select optional prescription drug coverage:**
   Prescription Plan : ❑Yes ❑ No
   Copayment Tier 1 Drugs ______________
   Copayment Tier 2 Drugs ______________
   Copayment Tier 3 Drugs ______________
   Prescription Deductible ______________
   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

5. **Additional Benefit Information (All information is subject to Home Office approval):**

   Vision: ❑ $50 exam/$70 appliances ❑ $50 exam/$200 appliances
   ❑ Domestic Partner (100+ life groups)

   ❑ Unlimited Home Healthcare ❑ Unlimited Skilled Nursing Facility
   Physical Therapy: ❒ Outpatient (90 visits per condition) ❒ Long-Term (100 visits per year)

   Dental: ❑ Premium ❑ Enhanced

   Emergency Room Copayment: ❑ $50 ❑ $75 (Standard) ❑ $100 ❑ $150

   Hospital Copayment (Inpatient/Outpatient): ❒ No Copayment ❒ $100/$50 ❒ $250/$100 (Standard) ❒ $500/$250
   ❒ $500 per day to $2,000 annual maximum/$250 ❒ $500 per day to $2,000 annual maximum/$100
   ❒ $500 per day to $2,000 annual maximum/$0

   Other (please specify) :______________________________________________

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## III. PRODUCT/PLAN DESIGN (continued)

### SECTION 2: Freedom Plan Direct

1. **Please check the box corresponding to the product selected:**
   ***Note:*** If more than one product/plan design has been selected, please attach a photocopy of this selection to your application specifying the additional information.

   ❑ **Freedom Plan Direct (Office Visit Copayment)** ❑ **Freedom Plan Direct (Deductible & Coinsurance Only)**

   **Please note:** No referrals are required for these plan designs.

2. **Please complete section below (if applicable):**
   Office Visit Copayment: ______________________________

   **In-network**
   Deductible: ______________________________
   Coinsurance: ______________________________
   Coinsurance Maximum: ______________________________

   **Out-of-network**
   Deductible: ___________________________
   Coinsurance: ______________________________
   Coinsurance Maximum: ______________________________
   Out-of-network Reimbursement:
   ______ UCR Fee schedule [1]
   ______ Medicare rate [2]

   Deductibles and out-of-pocket accumulation periods are on a ❑ calendar year basis ❑ contract year basis.

3. **Please select a prescription rider and desired coverages:**
   Prescription Plan : ❑ Yes ❑ No

   Copayment Tier 1 Drugs ______________
   Copayment Tier 2 Drugs ______________
   Copayment Tier 3 Drugs ______________
   Prescription Deductible ______________
   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

4. **Additional Benefit Information (All information is subject to Home Office approval):**

   Vision: ❑ $50 exam/$70 appliances ❑ $50 exam/$200 appliances

   ❑ Unlimited Skilled Nursing Facility ❑ Unlimited Home Healthcare

   ❑ Domestic Partners (100+ life groups)

   Emergency Room Copayment: (for office visit copayment plans only) ❐ $75 ❐ $100 ❐ $150

   Physical Therapy: ❐ Outpatient (90 visits per condition/lifetime) ❐ Long-Term (100 visits per calendar year)

   Dental: ❑ Premium ❑ Enhanced

   ❑ Other (please specify): ________________________________________________________________

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## III. PRODUCT/PLAN DESIGN (continued)

### SECTION 3: Freedom Plan Value Option

**1. Please complete section below (if applicable):**

❑ Office Visit Copayment: ______________________

**In-network**

Deductible: ____________________________

**Out-of-network**

Deductible: ____________________________

Coinsurance: ___________________________

Coinsurance Maximum: __________________

Out-of-network Reimbursement:

_____ UCR Fee schedule [1]

_____ Medicare rate [2]

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

Prescription Plan: ❐ Yes ❐ No

If yes, copayment information:

Tier 1: ______________________________

Tier 2: ______________________________

Tier 3: ______________________________

Prescription Deductible (if applicable): ______________________

Mail-Order

❐ 1x retail copayment for 90-day supply ❐ 2x retail copayment for 90-day supply

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

Deductible Options: (Deductibles are waived for Tier 1 drugs)

❐ None ❐ $50 ❐ $100* ❐ $150*

(*Available with 1x retail copayment mail-order only)

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

**3. Additional Benefit Information:**

| | | | | |
|---|---|---|---|---|
| Vision: | ❐ $50 exam/$70 appliances | ❐ $50 exam/$200 appliances | | |
| Emergency Room Copayment: | ❐ $50 | ❐ $75 (Standard) | ❐ $100 | ❐ $150 |
| Skilled Nursing Facility: | ❐ 30 Visits (Standard) | ❐ Unlimited | | |
| Outpatient Physical Therapy: | ❐ 60 Visits (Standard) | ❐ 90 Visits | | |

**Note:** Dental plans are not available for Freedom Plan Value Option plans.

Deductible and out-of-pocket accumulation periods are on a ❑ calendar year basis ❑ contract year basis.

## SECTION 4: Oxford MyPlan

Note: Groups enrolling in the Oxford MyPlan must also fill out an Oxford MyPlan Health Reserve Account Application Form (#6740).

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

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

❑ **Oxford MyPlan (Office Visit Copayment)** ❑ **Oxford MyPlan (Deductible & Coinsurance Only)**

**Please note:** No referrals are required for these plan designs.

**2. Please complete section below (if applicable):**

❑ Office Visit Copayment: ______________________ ❑ None (Deductible & Coinsurance Only)

**In-network**

Deductible: ____________________________

Coinsurance: ___________________________

Coinsurance Maximum: ___________________

**Out-of-network**

Deductible: ____________________________

Coinsurance: ___________________________

Coinsurance Maximum: ___________________

Out-of-network Reimbursement:

_____ UCR Fee schedule [1]

_____ Medicare rate [2]

**Please note:** Family deductible and out-of-pocket expenses are two times the single amount.

Deductibles and out-of-pocket accumulation periods are on a ❑ calendar year basis ❑ contract year basis.

**3. Please select a prescription rider and desired coverages:**

Prescription Plan: ❒ Yes ❒ No

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

If yes, copayment information:

Tier 1: ______________________________ Tier 2: ______________________________

Tier 3: ______________________________ Prescription Deductible (if applicable): ______________________

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

**4. Additional Benefit Information (All information is subject to Home Office approval):**

Vision: ❒ \$50 exam/\$70 appliances ❒ \$50 exam/\$200 appliances

Dental: ❑ Premium ❑ Enhanced

## III. PRODUCT/PLAN DESIGN (continued)

**SECTION 5:** Oxford HSA Direct

**Please note:** No referrals are required for these plan designs. Groups enrolling in the Oxford HSA Direct must also fill out an Oxford HSA Employer Notification Form (#7423).

1. **Please complete section below (if applicable): ***

**In-network**

Deductible:* ______________________________

Coinsurance: ______________________________

Coinsurance Maximum: ____________________

**Out-of-network**

Deductible: __________________________

Coinsurance: _________________________

Coinsurance Maximum: ________________

Out-of-network Reimbursement:
______ UCR Fee schedule [1]
______ Medicare rate [2]

Deductibles and out-of-pocket accumulation periods are on a ❑ calendar year basis ❑ contract year basis.

**Prescription Plan** (Required) *

Copayment Tier 1 Drugs _______________
Copayment Tier 2 Drugs _______________
Copayment Tier 3 Drugs _______________
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

***NOTE:** All in-network medical and pharmacy services are subject to the in-network deductible. Once the deductible has been satisfied, the applicable medical coinsurance and prescription drug copayment will apply based on the option selected at plan inception. Out-of-network benefits are accumulated separately.

2. **Additional Benefit Information (All information is subject to Home Office approval):**

Vision: ❑ $50 exam/$70 appliances ❑ $50 exam/$200 appliances

❑ Unlimited Skilled Nursing Facility ❑ Unlimited Home Healthcare

❑ Domestic Partners (100+ life groups)

Physical Therapy: ❒ Outpatient (90 visits per condition/lifetime) ❒ Long-Term (100 visits per calendar year)

Dental: ❑ Premium ❑ Enhanced

❑ Other (please specify): ________________________________________________

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## III. PRODUCT/PLAN DESIGN (continued)

**SECTION 6: Oxford USA** **Please select an Oxford USA plan from either Section A or B for out-of-area employees.**

### A) ❑ Oxford USA (non-gated POS options)

**1. Please complete section below:**

Office Visit Copayment: ____________

Deductible: ____________

Coinsurance (%): ____________

Coinsurance Maximum: ____________

Family Multiple (2,2.5,3): ____________

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

Out-of-network Reimbursement:

______ UCR Fee schedule [1]

______ Medicare rate [2]

**2. Please select optional prescription drug coverage:**

Prescription Plan: ❑ Yes ❑ No

If yes, copayment information:

Tier 1:______________

Tier 2:______________

Tier 3: ______________

Prescription Deductible (if applicable): ______________

Mail-Order

❑ 1x retail copayment for 90-day supply ❑ 2x retail copayment for 90-day supply

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:**

| | | | | |
|---|---|---|---|---|
| Domestic Partner: | ❑ (100+ life group) | ❑ Hospice | | |
| Vision: | ❑ $50 exam/$70 appliances | ❑ $50 exam/$200 appliances | | |
| Inpatient Hospital Room Copayment: | ❑ $0 (Standard) ❑ $100 | ❑ $250 | ❑ $500 | |
| Inpatient/Outpatient Hospital Room Copayment: | ❑ $100/$50 | ❑ $250/$100 | ❑ $500/$250 | |
| Outpatient Physical Therapy: | ❑ 60 Visits (Standard) | ❑ 90 Visits | ❑ Prosthetics | ❑ Enhanced Chiropractic |
| Emergency Room Copayment: | ❑ $50 | ❑ $75 (Standard) | ❑ $100 | ❑ $150 |
| Skilled Nursing Facility: | ❑ 30 Visits (Standard) | ❑ Unlimited | | |

## III. PRODUCT/PLAN DESIGN (continued)

### B) Oxford USA (Based on in-area Freedom Plan Direct)

1. ❑ **Oxford USA** (Office Visit Copayment) ❑ **Oxford USA** (Deductible & Coinsurance Only) ❑ **Oxford USA HSA** (Based on in area HSA Direct)

   **Please note: No referrals are required for these plan designs.**

2. **Please complete section below (if applicable):**
   Office Visit Copayment: ______________________

   **In-network**

   Deductible**: __________________________

   Coinsurance: __________________________

   Coinsurance Maximum: ____________________

   **Out-of-network**

   Deductible: _______________________

   Coinsurance: _________________________

   Coinsurance Maximum: _________________

   Out-of-network Reimbursement:
   _____ UCR Fee schedule [1]
   _____ Medicare rate [2]

   **Please note:** Family deductible and out-of-pocket expenses are two times the single amount.

   Deductibles and out-of-pocket accumulation periods are on a ❑ calendar year basis ❑ contract year basis.

3. **Please select a prescription rider and desired coverages:** (Required for HSA)**

   Prescription Plan: ❒ Yes ❒ No

   If yes, copayment information:
   Tier 1: ______________________________
   Tier 2: ______________________________
   Tier 3: ______________________________
   Prescription Deductible (if applicable): ________

   Contraceptives: ❒ Yes (Standard) ❒ No (Qualified State Exempt Groups Only)
   Medicare Part D 28% Subsidy - For the prescription plan design above, do you currently participate or plan to participate with the 28% Government Subsidy for your Medicare eligible retirees? ❑ Yes ❑ No

   ****NOTE: If selecting an Oxford USA HSA -**
   All in-network medical and pharmacy services are subject to the in-network deductible. Once the deductible has been satisfied, the applicable medical coinsurance and prescription drug copay will apply based on the option selected at plan inception. Out-of-network benefits are accumulated separately.

4. **Additional Benefit Information (All information is subject to Home Office approval):**

   Vision: ❑ $50 exam/$70 appliances ❑ $50 exam/$200 appliances

   ❑ Unlimited Home Healthcare

   ❑ Unlimited Skilled Nursing Facility

   ❑ Domestic Partners (100+ life groups)

   Physical Therapy: ❒ Outpatient (90 visits per condition) ❒ Long-Term (100 visits per year)

   Emergency Room Copayment: (for office visit copayment plans only) ❒ $75 ❒ $100 ❒ $150

   ❑ Other (please specify): ________________________________________________

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## 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 the Applicant is given notice of in conjunction with future renewals. The Applicant hereby acknowledges that if at any time he/she 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 does not accurately reflect, in the judgment of Oxford, the actual Applicant members covered by Oxford on the date coverage by Oxford first commences, then Oxford shall have the right at any time upon 30 days written notice to the Applicant to increase the monthly premiums payable by the Applicant in such amount as is determined by Oxford, in its absolute discretion, to reflect the increased risk of such non-compliance or census variance.*

____________________________________________________
Name of Company

____________________________________________________
Signature of Authorized Officer of Company | Title of Officer of Company | Date

## V. COBRA & EXTENSION OF BENEFITS DATA

1. Do you have any individuals currently on COBRA continuation? ❒ **Yes** ❒ **No**
   If yes, identify the number of individuals__________.

2. Are there any dependents of employees who are currently disabled or in the hospital? ❒ **Yes** ❒ **No**

   What is the length of the prior carrier's extension of benefits period for disabled employees or dependents? ______________________

## VI. CONSENT

**AUTHORIZATION FOR BROKER TO ACT AS BENEFITS ADMINISTRATOR**

The undersigned hereby requests Oxford to accept the Broker or General Agent named above as an authorized Benefits Administrator for purposes of processing any enrollment transactions for my company's insurance policy (including, but not limited to, Member enrollments, Member terminations, Member address changes, group contact changes, group address changes, plan renewal changes, and group contract terminations).

________________________________________
NAME OF BROKER OR GENERAL AGENT

This authorization shall be effective immediately and shall (check one only):

❒ Remain in place until it is expressly revoked by me in writing.

❒ Remain in place until ________________________.
DATE

Further, I agree that my company will be bound by the actions performed by the herein-named Broker or General Agent pursuant to this Consent Form. Additionally, I agree that this Consent Form does not authorize anyone to receive individually identifiable health information about any Member.
I acknowledge that I must notify Oxford in writing to void this agreement in the event of a change in my company's Broker of Record.

## VII. BROKER/AGENT AGREEMENT

| | 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.

## VIII. APPLICANT AGREEMENT

This application and the premium rates proposed by Oxford are subject to Home Office approval, in writing, by Oxford and may change due to differences in actual versus proposed enrollment, selection of benefits, changes in census data or underwriting criteria, or any other changes in underwriting as determined by Oxford. The Applicant hereby acknowledges that this application does not constitute any obligation by Oxford to offer coverage to the Applicant until such application is accepted, in writing, by the Home Office of Oxford. The Applicant hereby confirms that he/she will not cancel any current health coverage he/she may currently have in anticipation that this application will be accepted by Oxford, and that Oxford shall have no obligation to provide coverage to the Applicant unless this application is formally accepted, in writing, by the Oxford Home Office. Further, I hereby certify on behalf of the Applicant that the Applicant has not had a health insurance policy terminated within the past 12 months due to failure to pay
premiums.

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Dated at:________________this________________day of________________20________

________________________________
Applicant Name (Correct Legal Name)

X________________________________
Signature of Authorized Officer of the Applicant — Title of Officer of Applicant

X________________ X________________
Witness — Duly Licensed Resident Agent/Broker

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

[1] The Standard and High UCR fee schedules contain the maximum allowable fees and are set using data from Ingenix, Inc., the Centers for Medicare and Medicaid Services (CMS) and sources recognized by the federal government and insurance industry as a basis for evaluating and establishing fees. Physician fees are generally set using data from the Prevailing Healthcare Charges System (PHCS) database maintained by Ingenix. We use 70th percentile PHCS data for the standard UCR fee schedule and 80th percentile PHCS data for the high UCR fee schedule. We and Ingenix are related companies through common ownership by UnitedHealth Group. The fee schedule for physician-administered pharmaceutical products is based upon a percentage of Average Wholesale Price. If a data source is no longer available, we will use a comparable data source to establish fees.

[2] When a Medicare rate is not available, reimbursement is based upon certain gap methodology, including a gap methodology using relative value data from Ingenix, Inc. We and Ingenix are related companies through common ownership by UnitedHealth Group. When a gap methodology is not available, reimbursement is based upon 50% of the provider's billed charge.