UnitedHealthcare
Oxford

Freedom Plan®
Liberty Plan℠
Freedom Plan® Direct℠
Liberty Plan℠ Direct
Oxford® HSA Direct℠

New Jersey Small Employer Application – OHI

Oxford Health Insurance, Inc.

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

Please print or type

Policy Number (OHI 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 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 a 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? ____________________

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

16. **Other group health or HMO coverage:** Indicate below other group health coverage which is still in force or which terminated within the past three years.

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

II. SPECIFICATIONS FOR COVERAGE

PLEASE SELECT A PLAN FROM SECTION 1, 2 OR 3.

SECTION 1: FREEDOM PLAN & LIBERTY PLAN PRODUCT ❑ PPO ❑ POS NETWORK ❑ Freedom ❑ Liberty

NOTE: Not all plan combinations are available. Please refer to the rate model or contact your Sales Representative to verify the plan combination you selected is available.

Options	❑ Plan C	❑ Plan D
Office Copayment	❑ $5 ❑ $10 ❑ $15 ❑ $15/$25 ❑ $20 ❑ $25/$40 ❑ $30 ❑ $40 ❑ $50	❑ $5 ❑ $10 ❑ $15 ❑ $20
In-Network Coinsurance	❑ 80% ❑ 90% ❑ 100%	❑ 90% ❑ 100%
Out-Of-Network Deductible	❑ $200 ❑ $250 ❑ $300 ❑ $500 ❑ $750 ❑ $1,000 ❑ $2,500 ❑ $3,000 ❑ $3,500	❑ $200 ❑ $250 ❑ $300 ❑ $500 ❑ $750 ❑ $1,000
Maximum-Out-of-Pocket	❑ $5,000 ❑ $8,333 ❑ $10,000 ❑ $25,000	❑ $5,000 ❑ $10,000

OPTIONS:

❑ Hospital Confinement at no charge ❑ Vision Care Rider ❑ Enhanced Dental Rider
❑ Physical Therapy 90 Rider ❑ Domestic Partner ❑ Premium Dental Rider

PRESCRIPTION DRUG BENEFITS

Copayment Information: ❑ Base Plan (Out-of-Network Deductible and Coinsurance)
❑ Standard (Plan Copayment)

Optional Riders (Tier 1/ Tier 2/ Tier 3 Copayment) ❑ $5/$15/$50* ❑ $7/$20/$50* ❑ $7/$15/$25 ❑ $7/$15/$35* ❑ $10/$25/$50*
❑ $15/50%* ❑ $15/$30/$60** ❑ $15/$35/$75* ❑ $25/$50/$75*

*Pharmacy Deductible (applies to Tier 2 and Tier 3 drugs): ❑ None ❑ $50 ❑ $100** (mandatory for $15/$30/$60)

Oral Contraceptives: ❑ Yes ❑ No (Qualified State Exempt Groups Only)

SECTION 2: ❑ Freedom Plan Direct ❑ Liberty Plan Direct

Options	❑ Plan 1	❑ Plan 2	❑ Plan 3	❑ Plan 4	❑ Plan 5	❑ Plan 6	❑ Plan 7	❑ Plan 8	❑ Plan 9	❑ Plan 10	❑ Plan 11
Copayment	$15 PCP / $25 Specialist	$25 PCP / $40 Specialist	$25 PCP / $40 Specialist	N/A	N/A	N/A	$15 PCP / $25 Specialist	$25 PCP / $40 Specialist	$25 PCP / $40 Specialist	$30 PCP / $50 Specialist	$30 PCP / $50 Specialist
Single Deductible*	$500 / $1,000	$500 / $1,000	$1,000 / $2,000	$500 / $1,000	$2,000 / $2,000	$1,000 / $2,000	$1,000 / $2,000	$500 / $1,000	$1,000 / $2,000	$1,500 / $2,000	$2,500 / $2,500
Family Deductible*	$1,000 / $2,000	$1,000 / $2,000	$2,000 / $4,000	$1,000 / $2,000	$4,000 / $4,000	$2,000 / $4,000	$2,000 / $4,000	$1,000 / $2,000	$2,000 / $4,000	$3,000 / $4,000	$5,000 / $5,000
Coinsurance*	90%/70%	80%/60%	80%/60%	90%/70%	90%/70%	80%/60%	100%/70%	100%/70%	100%/70%	80%/60%	80%/60%
Single Max Out-of-Pocket	$1,500 / $4,000	$2,500 / $5,000	$3,000 / $6,000	$1,500 / $4,000	$3,000 / $5,000	$3,000 / $6,000	$1,000 / $5,000	$500 / $4,000	$1,000 / $5,000	$3,500 / $6,000	$4,500 / $6,500
Family Max Out-of-Pocket	$3,000 / $8,000	$5,000 / $10,000	$6,000 / $12,000	$3,000 / $8,000	$6,000 / $10,000	$6,000 / $12,000	$2,000 / $10,000	$1,000 / $8,000	$2,000 / $10,000	$7,000 / $12,000	$9,000 / $13,000

*In-network/Out-of-Network

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

DIRECT OPTIONS:

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

PRESCRIPTION DRUG BENEFITS

❑ Base Plan (Out of Network Deductible and Coinsurance)
❑ Plan Copayment (Available only with office visit Copayment plans)

Optional Riders (Tier 1/ Tier 2/ Tier 3 Copayment)

❑ $7/$15/$25 ❑ $10/$25/$50* ❑ $15/50%* ❑ $5/$15/$50* ❑ $7/$20/$50*
❑ $7/$15/$35* ❑ $15/$30/$60** ❑ $15/$35/$75* ❑ $25/$50/$75*

*Pharmacy Deductible (applies to Tier 2 and Tier 3 drugs): ❑ None ❑ $50 ❑ $100** (mandatory for $15/$30/$60)____________________

Oral Contraceptives: ❑ Yes ❑ No (Qualified State Exempt Groups Only)

SECTION 3: Oxford HSA Direct

Note: Groups enrolling in the Oxford HSA Direct are required to fill out a Certificate of Understanding Form (#8766). For groups electing to use OptumHealthBank, an Oxford HSA Employer Notification Form (#7423) must be completed.

HEALTH BENEFITS: ❑ Freedom Network ❑ Liberty Network

Options	❑ Plan 1	❑ Plan 2	❑ Plan 3	❑ Plan 4	❑ Plan 5	❑ Plan 6
Single Deductible** (In-network/Out-of-network)	$1,250/$2,000	$2,000/$2,000	$2,500/$2,500	$1,250/$2,000	$2,000/$2,000	$2,500/$2,500
Family Deductible** (In-network/Out-of-network)	$2,500/$4,000	$4,000/$4,000	$5,000/$5,000	$2,500/$4,000	$4,000/$4,000	$5,000/$5,000
Coinsurance (In-network/Out-of-network)	80%/60%	90%/70%	90%/70%	100%/70%	100%/70%	100%/70%
Single Medical Out-of-pocket Maximum (In-network/Out-of-network) (Family = 2x)	$3,250/$6,000	$3,000/$5,000	$3,500/$5,500	$1,250/$5,000	$2,000/$5,000	$2,500/$5,500

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

PRESCRIPTION DRUG BENEFITS:** (REQUIRED)

(Tier 1/ Tier2/ Tier 3 Copayment)

❑ $7/$15/$35 ❑ $10/$25/$50 ❑ $15/50% ❑ $25/$50/$75

Oral Contraceptives: ❑ Yes ❑ No (Qualified State Exempt Groups Only)

**NOTE: As of April 1, 2005, all in-network medical and pharmacy services are subject to the in-nework 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. No individual on a multiple person contract may satisfy the individual deductible and maximum out-of-pocket until the entire family deductible or maximum out-of-pocket have been met.

OXFORD HSA DIRECT OPTIONS (ALL INFORMATION IS SUBJECT TO HOME OFFICE APPROVAL)

❑ Vision ❑ Domestic Partner

❑ Premium Dental Rider ❑ Physical Therapy 90 Rider (30 visits standard)

❑ Enhanced Dental Rider

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 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 3 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 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.

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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

It is understood that, except as provided under applicable regulations, no individual shall become insured while not actively at work on a full-time basis, or retired, and only full-time employees and retiree's are eligible. A full-time employee is one who regularly works at least 25 hours per week at his 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 ____________________

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.

____
Print Name of Officer, Partner or Proprietor

____
Signature of Officer, Partner or Proprietor

____
Witness to Signature