UnitedHealthcare®
Oxford

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

❑ **New Policy** ❑ **Change in Policy**

Policy Number (OHI Use Only): ______________________

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 and 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 six 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 A, B, C OR D.

A. PLATINUM PLANS

Option	❑ Platinum EPO 15/40	❑ Platinum PPO Flex 20/40	❑ Platinum PPO Flex 15/45	❑ Platinum PPO 20/40
Network	❑ Freedom ❑ Liberty	❑ Freedom ❑ Liberty	❑ Freedom ❑ Liberty	❑ Freedom ❑ Liberty
Access	Non-gated	Non-gated	Non-gated	Non-gated
Copayment: **a. PCP** **b. Specialist**	$15 per visit $40 per visit	$20 per visit $40 per visit	$15 per visit $45 per visit	$20 per visit $40 per visit
In-Network Deductible (Single/Family)	N/A	N/A	N/A	N/A
In-Network Maximum Out-of-Pocket (Single/Family)	$2,500/$5,000	$2,500/$5,000	$2,500/$5,000	$2,000/$4,000
In-Network Coinsurance	N/A	N/A	N/A	N/A
Outpatient Facility Copayment	Freestanding Facility – $40 Hospital Facility – $150	Freestanding Facility – $50 Hospital Facility – $150	Freestanding Facility – No charge Hospital Facility – $150	Freestanding Facility – No charge Hospital Facility – $150
Inpatient Facility Copayment	$250 per day to $1,250 maximum per admit ($2,500 maximum per year)	$100 per day to $500 maximum per admit ($1,000 maximum per year)	$300 per day to $1,500 maximum per admit ($3,000 maximum per year)	No Charge
Emergency Room	$100	$100	$100	$100
Out-of-Network Deductible (Single/Family)	N/A	$2,000/$4,000	$2,500/$5,000	$1,000/$2,000
Out-of-Network Maximum Out-of-Pocket (Single/Family)	N/A	$5,000/$10,000	$6,250/$12,500	$4,000/$8,000
Out-of-Network Coinsurance	N/A	30%	30%	30%
Prescription Drug Coverage	**❑ Option 1** Tier 1 – $10 copayment Tier 2 – $25 copayment Tier 3 – $50 copayment Mail-Order – 2x copay Deductible – N/A **❑ Option 2** Tier 1 – $10 copayment Tier 2 – 15% copayment to $125 maximum Tier 3 – 35% copayment to a $200 maximum Mail-Order – 2x copay Deductible – N/A	**❑ Option 1** Tier 1 – $10 copayment Tier 2 – $25 copayment Tier 3 – $50 copayment Mail-Order – 2x copay Deductible – N/A **❑ Option 2** Tier 1 – $10 copayment Tier 2 – 15% copayment to $125 maximum Tier 3 – 35% copayment to a $200 maximum Mail-Order – 2x copay Deductible – N/A	**❑ Option 1** Tier 1 – $10 copayment Tier 2 – $25 copayment Tier 3 – $50 copayment Mail-Order – 2x copay Deductible – N/A **❑ Option 2** Tier 1 – $10 copayment Tier 2 – 15% copayment to $125 maximum Tier 3 – 35% copayment to a $200 maximum Mail-Order – 2x copay Deductible – N/A	**❑ Option 1** Tier 1 – $10 copayment Tier 2 – $25 copayment Tier 3 – $50 copayment Mail-Order – 2x copay Deductible – N/A **❑ Option 2** Tier 1 – $10 copayment Tier 2 – 15% copayment to $125 maximum Tier 3 – 35% copayment to a $200 maximum Mail-Order – 2x copay Deductible – N/A

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

Additional Benefit Options:
❑ Domestic Partner

Contraceptives ❑ Yes (Standard) ❑ No (Qualified State Exempt Groups Only)

II. SPECIFICATIONS FOR COVERAGE (CONTINUED)

B. GOLD PLANS

Option	❑ Gold EPO 50	❑ Gold EPO 30/50 $1000	❑ Gold EPO 30/60	❑ Gold EPO 25/40
Network	❑ Freedom ❑ Liberty	Liberty	Liberty	Liberty
Access	❑ Gated* ❑ Non-gated	❑ Gated* ❑ Non-gated	❑ Gated* ❑ Non-gated	Non-gated
Copayment: **a. PCP** **b. Specialist**	$50 per visit $50 per visit	$30 per visit $50 per visit	$30 per visit $60 per visit	$25 per visit $40 per visit
In-Network Deductible (Single/Family)	N/A	$1,000/$2,000	$2,000/$4,000	$1,000/$2,000
In-Network Maximum Out-of-Pocket (Single/Family)	$3,500/$7,000	$3,500/$7,000	$3,000/$6,000	$3,000/$6,000
In-Network Coinsurance	N/A	20%	50%	20%
Outpatient Facility Copayment	Freestanding Facility – $50 Hospital Facility – 50%	Freestanding Facility – $50 Hospital Facility – $150	Freestanding Facility – $150 Hospital Facility – $250	Freestanding Facility – $40 Hospital Facility – $150
Inpatient Facility Copayment	$500 per day to $2,500 maximum per admit	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Emergency Room	$100	$100 then Coinsurance	$100 then Coinsurance	$100 then Coinsurance
Prescription Drug Coverage	**❑ Option 1** Tier 1 – $15 copayment Tier 2 – $35 copayment Tier 3 – $75 copayment Mail-Order – 2x copay Deductible – N/A **❑ Option 2** Tier 1 – $15 copayment Tier 2 – 25% copayment to $125 maximum Tier 3 – 45% copayment to $150 maximum Mail-Order – 2x copay Deductible – N/A	**❑ Option 1** Tier 1 – $25 copayment Tier 2 – $50 copayment Tier 3 – $75 copayment Mail-Order – 2x copay Deductible – N/A **❑ Option 2** Tier 1 – $25 copayment Tier 2 – 30% copayment to $125 maximum Tier 3 – 50% copayment to $150 maximum Mail-Order – 2x copay Deductible – N/A	**❑ Option 1** Tier 1 – $15 copayment Tier 2 – $35 copayment Tier 3 – $75 copayment Mail-Order – 2x copay Deductible – N/A **❑ Option 2** Tier 1 – $15 copayment Tier 2 – 25% copayment to $125 maximum Tier 3 – 45% copayment to $150 maximum Mail-Order – 2x copay Deductible – N/A	**❑ Option 1** Tier 1 – $25 copayment Tier 2 – $50 copayment Tier 3 – $75 copayment Mail-Order – 2x copay Deductible – N/A **❑ Option 2** Tier 1 – $25 copayment Tier 2 – 30% copayment to $125 maximum Tier 3 – 50% copayment to $150 maximum Mail-Order – 2x copay Deductible – N/A

II. SPECIFICATIONS FOR COVERAGE (CONTINUED)

B. GOLD PLANS (CONTINUED)

Option	❑ Gold EPO 25/50	❑ Gold EPO 30/50 $2000	❑ Gold PPO Flex 25/40	❑ Gold PPO Flex 30/50
Network	Liberty	Liberty	❑ Freedom ❑ Liberty	❑ Freedom ❑ Liberty
Access	Non-gated	Non-gated	Non-gated	Non-gated
Copayment: a. PCP b. Specialist	$25 per visit $50 per visit	$30 per visit $50 per visit	$25 per visit $40 per visit	$30 per visit $50 per visit
In-Network Deductible (Single/Family)	$500/$1,000	$2,000/$4,000	$1,000/$2,000	$1,500/$3,000
In-Network Maximum Out-of-Pocket (Single/Family)	$4,000/$8,000	$5,000/$10,000	$3,000/$6,000	$2,750/$5,500
In-Network Coinsurance	50%	30%	20%	20%
Outpatient Facility Copayment	Freestanding Facility – $75 Hospital Facility – $150	Freestanding Facility – $50 Hospital Facility – $150	Freestanding Facility – Deductible then 20% Hospital Facility – Deductible then 50%	Freestanding Facility – Deductible then 20% Hospital Facility – Deductible then 50%
Inpatient Facility Copayment	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Emergency Room	$100 then Coinsurance	$100 then Coinsurance	$100 then Coinsurance	$100 then Coinsurance
Out-of-Network Deductible (Single/Family)	N/A	N/A	$3,000/$6,000	$4,000/$8,000
Out-of-Network Maximum Out-of-Pocket (Single/Family)	N/A	N/A	$7,500/$15,000	$10,000/$20,000
Out-of-Network Coinsurance	N/A	N/A	40%	40%
Prescription Drug Coverage	**❑ Option 1** Tier 1 – $25 copayment Tier 2 – $50 copayment Tier 3 – $75 copayment Mail-Order – 2x copay Deductible – N/A **❑ Option 2** Tier 1 – $25 copayment Tier 2 – 30% copayment to $125 maximum Tier 3 – 50% copayment to a $150 maximum Mail-Order – 2x copay Deductible – N/A	**❑ Option 1** Tier 1 – $15 copayment Tier 2 – $35 copayment Tier 3 – $75 copayment Mail-Order – 2x copay Deductible – N/A **❑ Option 2** Tier 1 – $15 copayment Tier 2 – 25% copayment to $125 maximum Tier 3 – 45% copayment to a $150 maximum Mail-Order – 2x copay Deductible – N/A	**❑ Option 1** Tier 1 – $15 copayment Tier 2 – $35 copayment Tier 3 – $75 copayment Mail-Order – 2x copay Deductible – N/A **❑ Option 2** Tier 1 – $15 copayment Tier 2 – 25% copayment to $125 maximum Tier 3 – 45% copayment to a $150 maximum Mail-Order – 2x copay Deductible – N/A	**❑ Option 1** Tier 1 – $10 copayment Tier 2 – $25 copayment Tier 3 – $50 copayment Mail-Order – 2x copay Deductible – N/A **❑ Option 2** Tier 1 – $10 copayment Tier 2 – 15% copayment to $125 maximum Tier 3 – 35% copayment to a $200 maximum Mail-Order – 2x copay Deductible – N/A

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

* Referrals are required for this plan design.

Additional Benefit Options:

❑ Domestic Partner

Contraceptives ❑ Yes (Standard) ❑ No (Qualified State Exempt Groups Only)

II. SPECIFICATIONS FOR COVERAGE (CONTINUED)

C. SILVER PLANS

Option	❑ Silver EPO 40/60	❑ Silver EPO 30/50 $500 Hosp	❑ Silver EPO 30/50	❑ Silver EPO HSA $2000 30/50**
Network	Liberty	Liberty	Liberty	Liberty
Access	❑ Gated* ❑ Non-gated	Non-gated	Non-gated	Non-gated
Copayment: **a. PCP** **b. Specialist**	$40 per visit $60 per visit	$30 per visit $50 per visit	$30 per visit $50 per visit	Deductible then $30 Deductible then $50
In-Network Deductible (Single/Family)	$2,500/$5,000	$2,500/$5,000	$2,500/$5,000	$2,000/$4,000
In-Network Maximum Out-of-Pocket (Single/Family)	$6,250/$12,500	$6,250/$12,500	$6,250/$12,500	$4,000/$8,000
In-Network Coinsurance	50%	50%	50%	N/A
Outpatient Facility Copayment	Freestanding Facility – Deductible then $125 Hospital Facility – Deductible then $250	Freestanding Facility – Deductible then $125 Hospital Facility – Deductible then $250	Freestanding Facility – Deductible then $125 Hospital Facility – Deductible then $250	Freestanding Facility – Deductible then no charge Hospital Facility – Deductible then $500
Inpatient Facility Copayment	$500 per admission	$500 per admission	Deductible and Coinsurance	Deductible then $500 per day ($1,500 max per year)
Emergency Room	$100 then Coinsurance	$100 then Coinsurance	$100 then Coinsurance	Deductible then $100
Prescription Drug Coverage	**❑ Option 1** Tier 1 – $25 copayment Tier 2 – $50 copayment Tier 3 – $75 copayment Mail-Order – 2x copay Deductible – N/A **❑ Option 2** Tier 1 – $25 copayment Tier 2 – 30% copayment to $200 maximum Tier 3 – 50% copayment to $400 maximum Mail-Order – 2x copay Deductible – N/A	**❑ Option 1** Tier 1 – $25 copayment Tier 2 – $50 copayment Tier 3 – $75 copayment Mail-Order – 2x copay Deductible – N/A	**❑ Option 1** Tier 1 – $25 copayment Tier 2 – $50 copayment Tier 3 – $75 copayment Mail-Order – 2x copay Deductible – N/A **❑ Option 2** Tier 1 – $25 copayment Tier 2 – 30% copayment to $200 maximum Tier 3 – 50% copayment to $400 maximum Mail-Order – 2x copay Deductible – N/A	**❑ Option 1** Tier 1 – $25 copayment Tier 2 – $50 copayment Tier 3 – $75 copayment Mail-Order – 2x copay Deductible** **❑ Option 2** Tier 1 – $25 copayment Tier 2 – 30% copayment to $125 maximum Tier 3 – 50% copayment to $150 maximum Mail-Order – 2x copay Deductible**

C. SILVER PLANS (CONTINUED)

Option	❑ Silver EPO 40/75 $1500	❑ Silver EPO 40/75	❑ Silver EPO 40/75 $2000	❑ Silver PPO Flex 50/75
Network	Liberty	Liberty	Liberty	❑ Liberty ❑ Freedom
Access	Non-gated	❑ Gated* ❑ Non-gated	Non-gated	Non-gated
Copayment: **a. PCP** **b. Specialist**	$40 per visit $75 per visit	$40 per visit $75 per visit	$40 per visit $75 per visit	$50 per visit $75 per visit
In-Network Deductible (Single/Family)	$1,500/$3,000	$2,000/$4,000	$2,000/$4,000	$2,000/$4,000
In-Network Maximum Out-of-Pocket (Single/Family)	$6,250/$12,500	$6,250/$12,500	$6,250/$12,500	$6,000/$12,000
In-Network Coinsurance	50%	50%	50%	30%
Outpatient Facility Copayment	Freestanding Facility – Deductible then 30% Coinsurance Hospital Facility – Deductible then 50% Coinsurance	Freestanding Facility – Deductible then $125 Hospital Facility – Deductible then $250	Freestanding Facility – Deductible then 30% Coinsurance Hospital Facility – Deductible then 50% Coinsurance	Freestanding Facility – Deductible then 30% Coinsurance Hospital Facility – Deductible then 50% Coinsurance
Inpatient Facility Copayment	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Emergency Room	$100 then Coinsurance	$100 then Coinsurance	$100 then Coinsurance	$100 then Coinsurance
Out-of-Network Deductible (Single/Family)	N/A	N/A	N/A	$5,000/$10,000
Out-of-Network Maximum Out-of-Pocket (Single/Family)	N/A	N/A	N/A	$12,500/$25,000
Out-of-Network Coinsurance	N/A	N/A	N/A	50%
Prescription Drug Coverage	**❑ Option 1** Tier 1 – $15 copayment Tier 2 – $35 copayment Tier 3 – $75 copayment Mail-Order – 2x copay Deductible – N/A **❑ Option 2** Tier 1 – $25 copayment Tier 2 – 30% copayment to $125 maximum Tier 3 – 50% copayment to $150 maximum Mail-Order – 2x copay Deductible – N/A	**❑ Option 1** Tier 1 – $25 copayment Tier 2 – $50 copayment Tier 3 – $75 copayment Mail-Order – 2x copay Deductible – N/A **❑ Option 2** Tier 1 – $25 copayment Tier 2 – 30% copayment to $200 maximum Tier 3 – 50% copayment to $400 maximum Mail-Order – 2x copay Deductible – N/A	**❑ Option 1** Tier 1 – $15 copayment Tier 2 – $35 copayment Tier 3 – $75 copayment Mail-Order – 2x copay Deductible – N/A **❑ Option 2** Tier 1 – $15 copayment Tier 2 – 25% copayment to $125 maximum Tier 3 – 45% copayment to $150 maximum Mail-Order – 2x copay Deductible – N/A	**❑ Option 1** Tier 1 – $25 copayment Tier 2 – $50 copayment Tier 3 – $75 copayment Mail-Order – 2x copay Deductible – N/A **❑ Option 2** Tier 1 – $25 copayment Tier 2 – 30% copayment to $125 maximum Tier 3 – 50% copayment to $150 maximum Mail-Order – 2x copay Deductible – N/A

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

* Referrals are required for this plan design.

**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. 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 has been met.

Additional Benefit Options:
❑ Domestic Partner

Contraceptives ❑ Yes (Standard) ❑ No (Qualified State Exempt Groups Only)

D. BRONZE PLANS

Option	❑ **Bronze PPO HSA 40/75****	❑ **Bronze PPO HSA $2500****
Network	❑ Liberty ❑ Freedom	❑ Liberty ❑ Freedom
Access	Non-gated	Non-gated
Copayment: **a. PCP** **b. Specialist**	Deductible then $40 per visit Deductible then $75 per visit	Deductible and Coinsurance Deductible and Coinsurance
In-Network Deductible (Single/Family)	$3,500/$7,000	$2,500/$5,000
In-Network Maximum Out-of-Pocket (Single/Family)	$6,250/$12,500	$6,250/$12,500
In-Network Coinsurance	40%	10%
Outpatient Facility Copayment	Freestanding Facility – Deductible then 40% Coinsurance Hospital Facility – Deductible then 50% Coinsurance	Freestanding Facility – Deductible then 10% Coinsurance Hospital Facility – Deductible then 50% Coinsurance
Inpatient Facility Copayment	Deductible and Coinsurance	Deductible and Coinsurance
Emergency Room	Deductible, then $100, then coinsurance	Deductible and Coinsurance
Out-of-Network Deductible (Single/Family)	$5,000/$10,000	$5,000/$10,000
Out-of-Network Maximum Out-of-Pocket (Single/Family)	$10,000/$20,000	$10,000/$20,000
Out-of-Network Coinsurance	50%	30%
Prescription Drug Coverage	❑ **Option 1** Tier 1 – $25 copayment Tier 2 – $50 copayment Tier 3 – $75 copayment Mail-Order – 2x copay Deductible** ❑ **Option 2** Tier 1 – $25 copayment Tier 2 – 30% copayment to $200 maximum Tier 3 – 50% copayment to a $400 maximum Mail-Order – 2x copay Deductible**	❑ **Option 1** Tier 1 – $25 copayment Tier 2 – $50 copayment Tier 3 – $75 copayment Mail-Order – 2x copay Deductible** ❑ **Option 2** Tier 1 – $25 copayment Tier 2 – 30% copayment to $125 maximum Tier 3 – 50% copayment to a $150 maximum Mail-Order – 2x copay Deductible**

II. SPECIFICATIONS FOR COVERAGE (CONTINUED)

BRONZE PLANS (CONTINUED)

Option	❑ Bronze EPO HSA $3500**	❑ Bronze EPO HSA $4000**	❑ Bronze EPO HSA 50/75**
Network	Liberty	Liberty	Liberty
Access	Non-gated	Non-gated	Non-gated
Copayment: **a. PCP** **b. Specialist**	Deductible and Coinsurance Deductible and Coinsurance	Deductible and Coinsurance Deductible and Coinsurance	Deductible then $50 per visit Deductible then $75 per visit
In-Network Deductible (Single/Family)	$3,500/$7,000	$4,000/$8,000	$2,500/$5,000
In-Network Maximum Out-of-Pocket (Single/Family)	$6,250/$12,500	$6,250/$12,500	$6,250/$12,500
In-Network Coinsurance	40%	30%	20%
Outpatient Facility Copayment	Freestanding Facility – Deductible then 40% Coinsurance Hospital Facility – Deductible then 50% Coinsurance	Freestanding Facility – Deductible then 30% Coinsurance Hospital Facility – Deductible then 50% Coinsurance	Freestanding Facility – Deductible then 20% Coinsurance Hospital Facility – Deductible then 50% Coinsurance
Inpatient Facility Copayment	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Emergency Room	Deductible and Coinsurance	Deductible and Coinsurance	Deductible then $100
Out-of-Network Deductible (Single/Family)	N/A	N/A	N/A
Out-of-Network Maximum Out-of-Pocket (Single/Family)	N/A	N/A	N/A
Out-of-Network Coinsurance	N/A	N/A	N/A
Prescription Drug Coverage	**❑ Option 1** Tier 1 – $25 copayment Tier 2 – $50 copayment Tier 3 – $75 copayment Mail-Order – 2x copay Deductible** **❑ Option 2** Tier 1 – $25 copayment Tier 2 – 30% copayment to $200 maximum Tier 3 – 50% copayment to a $400 maximum Mail-Order – 2x copay Deductible**	**❑ Option 1** Tier 1 – $25 copayment Tier 2 – $50 copayment Tier 3 – $75 copayment Mail-Order – 2x copay Deductible** **❑ Option 2** Tier 1 – $25 copayment Tier 2 – 30% copayment to $200 maximum Tier 3 – 50% copayment to a $400 maximum Mail-Order – 2x copay Deductible**	**❑ Option 1** Tier 1 – $25 copayment Tier 2 – $50 copayment Tier 3 – $75 copayment Mail-Order – 2x copay Deductible** **❑ Option 2** Tier 1 – $25 copayment Tier 2 – 30% copayment to $125 maximum Tier 3 – 50% copayment to a $150 maximum Mail-Order – 2x copay Deductible**

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

Additional Benefit Options:
❑ Domestic Partner

Contraceptives ❑ Yes (Standard) ❑ No (Qualified State Exempt Groups Only)

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 three or more months prior to application? ❑ Yes ❑ No

4. What forms of insurance are now or were in force?

   ❑ Health Benefits ❑ Prescription Drugs (Attach copies of Booklet/Certificate 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

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Witness to Signature