

New Jersey Small Group – 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 your Sales Representative to verify the plan combination you selected is available.

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

OPTIONS:

- Physician Visits for Preventive Care at no charge
- Hospital Confinement at no charge
- Physical Therapy 90 Rider
- Vision Care Rider
- Enhanced Dental Rider
- Premium Dental Rider
- Domestic Partner

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** (\$3,000 max)

*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	<input type="checkbox"/> Plan 1	<input type="checkbox"/> Plan 2	<input type="checkbox"/> Plan 3	<input type="checkbox"/> Plan 4	<input type="checkbox"/> Plan 5	<input type="checkbox"/> Plan 6	<input type="checkbox"/> Plan 7	<input type="checkbox"/> Plan 8	<input type="checkbox"/> Plan 9
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
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
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
Coinsurance	90%/70%	80%/60%	80%/60%	90%/70%	90%/70%	80%/60%	100%/70%	100%/70%	100%/70%
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	\$3,000/\$6,000	\$1,500/\$4,000	\$3,000/\$6,000
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	\$6,000/\$12,000	\$3,000/\$8,000	\$6,000/\$12,000

DIRECT OPTIONS:

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

PRESCRIPTION DRUG BENEFITS

- Copayment Information: Base Plan (Out of Network Deductible and Coinsurance)
 Standard (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** (\$3,000 max)

*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 MYPLAN

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

HEALTH BENEFITS:

- Freedom Network Liberty Network

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

Options	<input type="checkbox"/> Plan 1	<input type="checkbox"/> Plan 2	<input type="checkbox"/> Plan3
Copayment	\$25/\$40	N/A	N/A
Single Deductible (In-network/Out-of-network)	\$1,000/\$2,000	\$2,000/\$2,000	\$1,000/\$2,000
Family Deductible (In-network/Out-of-network)	\$2,000/\$4,000	\$4,000/\$4,000	\$2,000/\$4,000
Coinsurance (In-network/Out-of-network)	80%/60%	90%/70%	80%/60%
Single Out of Pocket Maximum (Family = 2x)	\$3,000/\$6,000	\$3,000/\$5,000	\$3,000/\$6,000

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

- Vision Domestic Partner

PRESCRIPTION DRUG BENEFITS:

Prescription Drug Plan: Yes No

Copayment Information: Base Plan (Out of Network Deductible and Coinsurance)
 Standard (Plan Copayment) Available only with Plan #1.

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

- \$7/\$15/\$25 \$10/\$25/\$50* \$15/50%*

*Pharmacy Deductible (applies to Tier 2 and Tier 3 drugs): None \$50 \$100

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

SECTION 4: 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 Exante Bank, an Oxford HSA Employer Notification Form (#7423) must be completed.

HEALTH BENEFITS: Freedom Network Liberty Network

Options	<input type="checkbox"/> Plan 1	<input type="checkbox"/> Plan 2	<input type="checkbox"/> Plan 3	<input type="checkbox"/> Plan 4	<input type="checkbox"/> Plan 5	<input type="checkbox"/> 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

PRESCRIPTION DRUG BENEFITS: (REQUIRED)**

(Tier 1/ Tier2/ Tier 3 Copayment)

- \$7/\$15/\$35 \$10/\$25/\$50 \$15/50%

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-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. 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.

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: _____

Broker: Name _____ Code _____ Address _____

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 Health Insurance, Inc. to make or modify any request or application for insurance or to bind Oxford Health Insurance, Inc. 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 Health Insurance, Inc. 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

CERTIFICATION AS A SMALL EMPLOYER IN THE STATE OF NEW JERSEY IN ACCORDANCE WITH NEW JERSEY CH. 162

Group Health Benefits Policy Participation

All Questions Must Be Answered

An Eligible Employee is one who works on a full-time basis with a normal work week of 25 or more hours for pay. An employee who works less than 25 hours per week, on a temporary or substitute basis, or an employee participating in an employee welfare arrangement established pursuant to a collective bargaining agreement is not an eligible employee.

Total Number of Eligible Employees _____

Total Number of Eligible Employees applying/enrolling for health benefits coverage _____

Total Number of Eligible Employees waiving health benefits coverage under the policy with coverage under their spouse's coverage, other than individual coverage; or any other Health Benefits Plan offered by the employer _____

Total Number of Eligible Employees waiving health benefits coverage under the policy without coverage under a spouse's coverage, other than individual coverage; or any other Health Benefits Plan offered by the employer _____

Total Number of Employees in an ineligible class or classes _____

Is your firm subject to Working Aged Provisions (TEFRA / DEFRA)? Yes No

Is your firm subject to the requirements of COBRA? Yes No

CERTIFICATION

Please sign and date appropriate section indicating whether or not you meet the definition of a small employer.

Small Employer means, in connection with a Group Health Plan with respect to a Calendar Year and a Plan Year, any person, firm, corporation, partnership, or political subdivision that is actively engaged in business that employed an average of at least two but not more than 50 eligible Employees on business days during the preceding Calendar Year and who employs at least two Employees on the first day of the Plan Year, and the majority of the Employees are employed in New Jersey. All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer. In the case of an employer that was not in existence during the preceding Calendar Year, the determination of whether the employer is a small or large employer shall be based on the average number of Employees that it is expected that the employer will employ on business days in the current Calendar Year.

I certify that the information provided to Oxford is true and complete. I understand that if the above information is not complete or is not provided to Oxford in a timely manner, then health benefits coverage does not have to be offered or continued. I further understand that incomplete or untrue information may void health benefits coverage.

I understand that I and my employees may be subject to fines if an employee who is a resident of New Jersey and is eligible for coverage under this group health benefits plan is enrolled in an individual health benefits plan issued on or after August 1, 1993.

Any person who includes any false or misleading information on an application or enrollment form or certification for a health benefits plan is subject to criminal and civil penalties.

Signature of Officer, Partner or Owner *Title* *Date*

Print Name of Officer, Partner, or Owner

Signature of Witness *Date*

I certify that I am not a Small Employer in the State of New Jersey, as defined above.

Signature of Officer, Partner or Owner *Title* *Date*

Print Name of Officer, Partner, or Owner

Signature of Witness *Date*

OTHER ITEMS REQUIRED WITH SUBMISSION OF POLICY

WR30

ATTACH A COPY OF YOUR WR30 (WAGE & PAYROLL) FOR THE LASTEST QUARTER OR APPROPRIATE TAX DOCUMENTATION

- ✓ *OXFORD REQUIRES NO WR30*
- ✓ *AETNA REQUIRES WR30 FOR LESS THAN 5 ENROLLING, BUT IT IS A 6 EE ELIGIBLE GROUP*
- ✓ *ALL OTHER CARRIERS REQUIRE WR30 2-5 ELIGIBLE. IN OTHER WORDS IF THE GROUP HAS 6 ELIGIBLE EMPLOYEES, BUT ONLY 3 ENROLLING, WR30 IS NOT NECESSARY UNLESS UNDERWRITING COMES BACK AND MAKES A REQUEST TO SEE IT.*

CARRIER BILL

A COPY OF YOUR LAST BILLING STATEMENT SHOWING ALL THE EMPLOYEES ENROLLED FROM YOUR PREVIOUS CARRIER

PREMIUM CHECK

ALL NEW CASES MUST SUBMIT A CHECK MADE OUT TO THE CARRIER WITH THE ESTIMATED MONTHLY PREMIUM AMOUNT FROM THE QUOTE. THIS MUST BE A COMPANY BUSINESS CHECK

QUOTE

ATTACH A COPY OF THE QUOTED ESTIMATED PREMIUM. PLEASE CIRCLE THIS PLAN DESIGN AND AMOUNT AND HAVE THE CLIENT SIGN THEIR NAME ANYWHERE WITHIN THE PLAN DESCRIPTION OR BY THE RATES. THIS IS AN ACKNOWLEDGEMENT OF PLAN DESIGN/RATES QUOTED.

TERMINATION OF PRIOR CARRIER

DON'T FORGET TO SEND A LETTER OFF TO THE PRIOR CARRIER, CANCELLING THE COVERAGE. PLEASE DO NOT DO SO UNTIL YOU RECEIVE APPROVAL ON THE COVERAGE THAT YOU ARE APPLYING FOR. PLEASE NOTE THAT ALL CARRIERS REQUIRE YOU TO CANCEL PRIOR OR 30 DAYS BEFORE YOUR EFFECTIVE DATE OF YOUR RENEWAL. OTHERWISE, THEY HAVE THE RIGHT TO BILL YOU. SO, YOU MAY WANT TO PUSH OUT YOUR NEW COVERAGE EFFECTIVE DATE. PLEASE CONSULT YOUR BROKER TO CHECK ON TIMEFRAMES.

New Jersey Small Employer - Member Enrollment/Change Request Form - OHI

Oxford Health Insurance, Inc.

Mailing Address: P.O. Box 7085, Bridgeport, CT 06601 • 1-800-444-6222 • www.oxfordhealth.com

Instructions

Employer

- Complete the Employer Group Information in the upper right corner of the form.
- **Section A - Type of Activity:** Check box(es) indicating reason(s) for submitting application.
- Complete **Section I Employer Verification** at the bottom of the form.
 - Employer must complete this section for all new enrollments, coverage changes and terminations.
 - Employer must sign and date the Enrollment/Change Request Form in order for it to be processed.

Employee - Complete Sections B-H

Section B - Employee Information:

- Complete all information in order for your application to be processed.

Section C - Plan Option:

- Indicate Plan Option selected and the type of contract.
- Select only an option offered by your employer.

Section D - Individuals Covered:

- Add/Change/Remove - Use "A", "C", or "R" to indicate whether you are adding, changing or removing coverage for an individual.
- Print your full name along with the name(s) of your dependent(s), if applicable. Indicate Sex, Birthdate, and Social Security Number for each individual listed.
- If a dependent is a full-time college student at an accredited school, you must attach proof of full-time student status, such as a paid bill/tuition statement, a Student Verification Form, or a letter from the registration/bursar's office confirming enrollment.
- If you or your dependent(s) have other health coverage, check off the "Yes" box(es) and complete Section F - Other/Previous Insurance.
- From the appropriate provider roster, locate the office ID number for the primary care physician, ob/gyn (if applicable) and/or dentist (if applicable). Indicate provider ID number selection(s) on the form.
- If you are a current patient, please check the "Current Patient" box.

Section E - Pre-Existing Conditions Statement:

- Complete this section for all new enrollments. **Exceptions:** For Small Employer Group coverage, this section must be completed only by persons enrolling in group coverage in a group of 2-5 employees and by late entrants.

Section F - Other/Previous Insurance:

- Complete this section for all new enrollments or coverage changes. Coverage includes group coverage, governmental coverage, a church plan or Medicare.

Section G - Dependent Information:

- Complete this section for all new enrollments or coverage changes.

Section H - Employee Signature:

- Complete this section for all new enrollments, coverage changes and terminations.
- Employee must sign and date the Enrollment/Change Request Form in order for it to be processed.

Section I - Employer Verification:

- Employer must complete this section for all new enrollments, coverage changes and terminations.
- Employer must sign and date the Enrollment/Change Request Form in order for it to be processed.

Conditions of Enrollment Applicant Acknowledgments and Agreements

On behalf of myself and the dependents listed on the form, I agree to or with the following:

- (a)** I authorize the sources stated below to give to Oxford Health Insurance, Inc. ("OHI"), or any consumer reporting agency acting on its behalf, information about me or my minor children, if applying for coverage. Such information will pertain to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition. Authorized sources are any physician or medical professional; any hospital, clinic or other medical care institution; any carrier; any consumer reporting agency; any employer.
 - (b)** I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action, which OHI has taken in reliance on the authorization. I understand this authorization will not be valid after 30 months, if not revoked earlier.
 - (c)** I know that I have a right to receive a copy of the authorization if I request one.
 - (d)** I agree that a photocopy of this authorization is as valid as the original.
2. I acknowledge by enrolling in an OHI plan that coverage is provided by OHI in accordance with the contract.
 3. Enrollment of myself and of the listed dependent(s) into the plan is effective on acceptance by OHI.
 4. Coverage and benefits are contingent on timely payment of premiums and may be terminated as provided in the plan documents. My employer is hereby authorized to withhold payments from my wages, as appropriate.

Misrepresentation

5. Any person who includes any false or misleading information on an Enrollment/Change Request Form for a health benefits plan is subject to criminal and civil penalties.

Please do not write in this area, for Insurer use only.

Employer Group Information- To be completed by employer			
Group name	Group number	(CSP)	Billing group

New Jersey Small Employer - Member Enrollment/Change Request Form - OHI

Oxford Health Insurance, Inc.

Mailing Address: P.O. Box 7085, Bridgeport, CT 06601-7085 • 1-800-444-6222 • www.oxfordhealth.com

A. Type of Activity - To Be Completed By EMPLOYER Refer to instructions attached before completing this form. (Please Print Clearly)

1). Enrollment <input type="checkbox"/> New employee	2). Change-Check all that apply <input type="checkbox"/> Add spouse <input type="checkbox"/> Add dependent child <input type="checkbox"/> Name change <input type="checkbox"/> Change plan <input type="checkbox"/> Other <input type="checkbox"/> Add/Change PCP or OB/GYN	Date of Event / /	Reason	3). Remove or Terminate-Check all that apply <input type="checkbox"/> Remove spouse <input type="checkbox"/> Remove dependent child <input type="checkbox"/> Employee withdrawal/termination	Eff. Date / /	Reason	4). Continuation of coverage. i.e., COBRA, State, Total Disability (Not all options are available or applicable. Contact employer for available options) Coverage for: <input type="checkbox"/> Employee <input type="checkbox"/> Dependent(s) Length of Continuation: <input type="checkbox"/> 12mos <input type="checkbox"/> 18mos <input type="checkbox"/> 29 mos <input type="checkbox"/> 36 mos <input type="checkbox"/> Total Disability* *Attach proof of total disability Date of Loss of Coverage: ____/____/____ Date of Qualifying Event: ____/____/____
		Effective Date / /	<input type="checkbox"/> Add/Change PCP or OB/GYN Eff. Date: / /		NOTE: Employee must be enrolled for spouse/dependent(s) to have coverage. *Please complete Add/Change/Remove and Name columns in Section D.		

B. Employee Information - Complete Sections B-H (Please Print Clearly) C. Plan Option

Social Security No.	Last Name, First Name, M.I.		Home Telephone ()
Home Address	Apt No.	City, State	Zip Code
Employer Name	Date of Employment / /	Hours Worked per Week	Work telephone ()
Work Address	City, State		Zip Code

Your selection must be offered by your employer

1. Indicate plan selected

2. Type of Contract:
 Single Adult & Child(ren)
 Family Husband/Wife

D. Individuals Covered - List individuals for whom you are adding/changing/removing coverage. Attach sheet to list additional children (attach proof if full-time college student).

	(A)dd (C)hange (R)emove	Last Name, First Name, M.I.	Sex		Birthdate MM DD YY	Social Security Number	Other Health Coverage	PCP ID #	Other Rx Drug Coverage	Current Patient?	OB/GYN ID #	Current Patient?
			M	F								
Employee					/ /		<input type="checkbox"/> Yes		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes		<input type="checkbox"/> Yes
Spouse					/ /		<input type="checkbox"/> Yes		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes		<input type="checkbox"/> Yes
Child					/ /		<input type="checkbox"/> Yes		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes		<input type="checkbox"/> Yes
Child					/ /		<input type="checkbox"/> Yes		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes		<input type="checkbox"/> Yes
Child					/ /		<input type="checkbox"/> Yes		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes		<input type="checkbox"/> Yes

E. Pre-Existing Conditions Statement

Note: This information may only be used to determine if a condition is a pre-existing condition. You CANNOT be denied coverage under a health benefits plan on the basis of accurate responses to the following questions. Carriers can only use the information to expedite the processing of claims.

<input type="checkbox"/> Yes <input type="checkbox"/> No	1. During the past 6 months, have you or any dependent to be covered had or been diagnosed as having any of the following? If "yes", check appropriate boxes below: <input type="checkbox"/> a. Alcoholism or drug abuse <input type="checkbox"/> b. Arthritis <input type="checkbox"/> c. Blood disorder <input type="checkbox"/> d. Back or neck disorder, injury or pain <input type="checkbox"/> e. Cancer or tumors <input type="checkbox"/> f. Diabetes <input type="checkbox"/> g. Gastro or intestinal disorder <input type="checkbox"/> h. Heart disorder/condition or chest pain <input type="checkbox"/> i. High blood pressure <input type="checkbox"/> j. Kidney or liver disorder <input type="checkbox"/> k. Lung or respiratory disorder <input type="checkbox"/> l. Mental or nervous disorder <input type="checkbox"/> m. Paralysis, stroke or epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	2. During the past 6 months, have you or any dependent to be covered: <input type="checkbox"/> a. been examined or treated by a physician or other healthcare provider for any condition, illness, or injury, other than as stated above? <input type="checkbox"/> b. been advised to have treatment or surgery or testing that has not yet been done? <input type="checkbox"/> c. been admitted to a hospital or other healthcare facility as an inpatient? <input type="checkbox"/> d. prescribed medications?

Please give details for "yes" answers to any part of Questions 1 or 2 on a separate sheet of paper. This separate sheet should be signed and dated.

F. Other/Previous Insurance

Is your spouse employed? Yes No

If "yes", give name and address of your spouse's employer:

If "yes" to Other Health Coverage (Section D), give name and policy number of insurance carrier or HMO, or other source.

If enrolled in Medicare Parts A and/or B, identify the coverage and provide the Medicare ID#:

If "yes" to previous coverage, identify names of persons, give effective date and date coverage terminated, name of previous carrier and plan number:

If "Yes" to Other Rx Drug Coverage (Section D), give name and policy number of insurance carrier, HMO, or other source.

G. Dependent Information

Does any dependent listed in Section D live at a different address than the employee? Yes No

If "yes", who and at what address?

Explain the circumstances:

If any dependent's last name differs from yours, explain the circumstances.

H. Employee Signature

If you have questions concerning the benefits and services provided by or excluded under this policy, contact a Customer Service representative at 1-800-444-6222 before signing this form.

I represent that all the information supplied in this Enrollment/Change Request Form is true and complete. I hereby agree to the conditions of the employee copy of this Enrollment/Change Request Form. I authorize deductions from my earnings for any required contributions.

Employee Signature – Required

X

Date

E-mail Address _____

I. Employer Verification - To Be Completed by EMPLOYER

Employer Signature – Required

X

Title

Date

Employee copy may be used as a temporary ID card for 30 days from the effective date if authorized by the employer. Coverage must be verified with Oxford Health Plans prior to visiting a specialist or admission to a hospital.

New Jersey Small Employer Health Benefits Waiver of Coverage

Mailing Address: P.O. Box 7085, Bridgeport, CT 06601-7085 • 800-385-9088

Group Policy Number:

Policyholder Name:

Employee Name: Last First Middle Initial

Social Security Number:

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 (NJ), Inc./Oxford Health Insurance, Inc. I *refuse* the following:

- Employee, Spouse and Child(ren) coverage
- Spouse coverage
- Child(ren) coverage

Reason for Refusal (Please check all appropriate lines.)

- Other Group Health Plan sponsored by this employer
- Other Group Health Plan sponsored by my spouse's employer
- Other Group Health Plan sponsored by another organization
- Other reasons (please explain) _____

Please identify Group Health Plan(s) and provide name(s) of Policyholder(s), carrier(s) and policy number(s):

Policyholder Name: _____ Policyholder Name: _____

Carrier: _____ Carrier: _____

Policy Number: _____ Policy Number: _____

If you are declining enrollment for yourself or your dependents (including your spouse) because of other Group Health Plan coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If the reason for refusal of coverage is coverage under another Group Health Plan, it is important to provide information concerning that Group Health Plan on this Waiver of Coverage form. If you fail to provide this information on this Waiver of Coverage form and you later become ineligible for such other coverage and then wish to enroll in any of the refused coverages, you will be considered a Late Enrollee and may be subject to the pre-existing conditions exclusion.

I understand that if I later wish to enroll for any of the coverage(s) refused, I will be required to submit an Enrollment Form and Pre-Existing Conditions Statement, and coverage may be subject to a pre-existing conditions exclusion.

Signature of Employee Date

Signature of Benefits Administrator Date

BULLETIN NO. 08-16

TO: ALL NEW JERSEY LICENSED INSURERS TRANSACTING HEALTH INSURANCE BUSINESS; HOSPITAL, MEDICAL HEALTH AND DENTAL SERVICE CORPORATIONS; DENTAL PLAN ORGANIZATIONS, PREPAID PRESCRIPTION PLANS AND HEALTH MAINTENANCE ORGANIZATIONS; ALL NEW JERSEY LICENSED HEALTH INSURANCE PRODUCERS

FROM: STEVEN M. GOLDMAN, COMMISSIONER

RE: PRODUCER COMPENSATION DISCLOSURES

P.L. 2008, c. 38 (the Act), was approved on July 8, 2008 and becomes effective on January 5, 2009. Among other things, section 25 of the Act amends the New Jersey Producer Licensing Act of 2001 (codified at N.J.S.A. 17:22A-26 et seq.) by requiring licensed insurance producers to disclose to health insurance purchasers any compensation received from the sale of such policies or contracts. Section 25 of the Act states:

a. An insurance producer licensed pursuant to P.L. 2001, c. 210 (C. 17:22A-26 et seq.) who sells, solicits, or negotiates health insurance policies or contracts to residents of this State shall notify the purchaser of the insurance, in writing, of the amount of any commission, service fee, brokerage, or other valuable consideration that the producer will receive as a result of the sale, solicitation or negotiation of the health insurance policy or contract. If the commission, fee, brokerage, or other valuable consideration is based on a percentage of premium, the insurance producer shall include that information in the notification to the purchaser.

b. The commissioner may specify, by regulation, the information that shall be provided by an insurance producer in the notification to a purchaser of health insurance and the procedure for providing the notification.

N.J.S.A. 17:22A-28 defines an “insurance producer” as a person required to be licensed under the laws of this State to sell, solicit or negotiate insurance. The term includes insurance brokers, agents and consultants, and general agents.

The purpose of this Bulletin is to notify producers, and carriers who compensate producers, of the requirements of Section 25 of the Act and to clarify the Department’s position concerning implementation of this section pending the Department’s proposal of regulations.

• **Scope of Disclosure:** Disclosure is required for any insurance contract that meets the definition of “health insurance” at N.J.S.A. 17B:17-4 and for any contract sold by non-insurance health carriers, such as hospital, medical, health and dental service corporations; dental plan organizations, prepaid prescription plans and health maintenance organizations. Disclosure is not required for health coverage that is an incidental part of a life or annuity contract.

• **What must be Disclosed:** Any valuable consideration, including but not limited to commissions or service fees, must be disclosed. Consideration must be disclosed even if its amount cannot be calculated or estimated. However, the precise nature of the compensation (e.g., commission vs. service fee) does not need to be disclosed. In the case of standard

commission rates, the commission percentage or the per employee amount of commission in connection with a rate proposal, binder or bill may be disclosed.

- **Who Provides Disclosure:** The Act requires that the producer provide the disclosure to the insurance purchaser, however in many cases it may be more efficient for the carrier to provide the disclosure.

- **Timing of Disclosure:** The Act does not imply that disclosure must be made at the time of proposal or prior to a contract becoming effective. Disclosure should be made no later than the effective date of the contract.

- **Form of Disclosure:** Attached is a suggested form that may be used for compliance with the Act's compensation disclosure requirements. Use of an alternate form is acceptable so long as the Act's written compensation disclosure requirements are met.

10/01/08
Date

/s/ Steven M. Goldman, Commissioner
Steven M. Goldman, Commissioner

Inoord/bbProducerComp

**DISCLOSURE OF A FINANCIAL INTEREST
IN THE SALE OF HEALTH INSURANCE POLICIES**

New Jersey law (N.J.S.A. 17:22A-41.1) requires disclosure of the compensation a licensed agent or broker (producer) receives from your purchase or renewal of health coverage. Compensation may be in the form of a commission, fee(s), or possibly other valuable consideration, or a combination of all three.

The per employee dollar amount(s) or percentage(s) of premium are in the table below. All amounts and/or percentages are additive. If something does not apply, it is marked "None" or "NA". If there is compensation, whether or not in addition to the compensation shown, whose amount cannot be determined, enter "CBD" (cannot be determined) on the appropriate line. Use the "Other" line for all other compensation, whether or not the amount is determinable.

	Agent/Producer	
	Percentage (%)	Amount in Dollars (\$) (per employee basis)
Commission of Issuing Agent		
Commission of General Agent		
Consultant Fee		
Brokerage Fee		
Other:		

PRODUCER INFORMATION

Agent Name: _____

General Agent Name: _____

CARRIER INFORMATION

Company Name: _____

_____ [_____
Date Agent/Producer Signature]¹

¹Carriers: omit this signature block if sending the disclosure form directly to the purchaser.



A UnitedHealthcare Company

Student Verification Parent Affidavit Form

Mailing Address: P.O. Box 7085, Bridgeport, CT 06601-9688 • 1-800-444-6222

Welcome.

To be eligible for student dependent coverage we require verification of full-time student status, please submit verification for the current semester.

Please arrange to have this postage-paid Student Verification Information Form submitted to us at the time of your enrollment.

If your child is not a full-time student, he or she may still be eligible for coverage. For more information, please contact the Benefits Administrator at your company.

If you have any questions, please call our Customer Service Department at 1-800-444-6222.

Thank you.

TO BE COMPLETED BY THE SUBSCRIBER

Employer Name

Subscriber Name

Subscriber Social Security #

Name of Student

Student Social Security #

Name of School

Address

Phone

I confirm that the above named dependent is registered as a full-time part-time student at an accredited educational institution for the ___/___/___ semester, which begins on ___/___/___ and ends ___/___/___.

I attest that the information shown above is true and complete. I understand that failure to complete this form may result in delayed, denied or termination of coverage for the above named dependent. I understand that Oxford Health Plans reserves the right to request additional information as proof of the above-named dependent's full-time status.

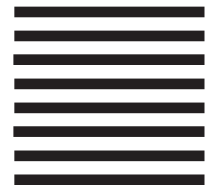
Further, any person who knowingly and with intent to defraud an insurance company or other person files a statement or claim containing any materially false information concerning any material fact thereto, commits a fraudulent insurance act, which is a crime, and is also subject to a civil penalty.

Subscriber's Signature

Date



NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES



BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO. 53 NORWALK, CT

POSTAGE WILL BE PAID BY ADDRESSEE:

OXFORD HEALTH PLANS, A UNITEDHEALTHCARE COMPANY
ATTENTION: STUDENT VERIFICATION
P.O. BOX 7085
BRIDGEPORT, CT 06601-9688



III. OXFORD USA FREEDOM DIRECT PLAN DESIGNS

HEALTH BENEFITS

Options	<input type="checkbox"/> Plan 1	<input type="checkbox"/> Plan 2	<input type="checkbox"/> Plan 3	<input type="checkbox"/> Plan 4	<input type="checkbox"/> Plan 5	<input type="checkbox"/> Plan 6
Copayment	\$15 PCP \$25 Specialist	\$25 PCP \$40 Specialist	\$25 PCP \$40 Specialist	N/A	N/A	N/A
Single * Deductible	\$500/\$1,000	\$500/\$1,000	\$1,000/\$2,000	\$500/\$1,000	\$2,000/\$2,000	\$1,000/\$2,000
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
Coinsurance *	90%/70%	80%/60%	80%/60%	90%/70%	90%/70%	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
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

DIRECT OPTIONS:

- Vision Care Rider Domestic Partner

PRESCRIPTION DRUG BENEFITS

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

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

- \$7/\$15/\$25 \$10/\$25/\$50* \$15/50%* \$5/\$15/\$50* \$7/\$20/\$50* \$7/\$15/\$35* \$15/\$30/\$60** (\$3,000 max)
*Pharmacy Deductible (applies to Tier 2 and Tier 3 drugs): None \$50 \$100** (mandatory for \$15/\$30/\$60)

IV. OXFORD USA HSA DIRECT PLAN DESIGNS

OXFORD® HSA DIRECTSM

Note: Groups enrolling in the Oxford HSA Direct must also fill out an Oxford HSA Banking Notification Form (#7423)

HEALTH BENEFITS:

Options	Plan1	<input type="checkbox"/> Plan 2	<input type="checkbox"/> Plan3	<input type="checkbox"/> Plan 4	<input type="checkbox"/> Plan 5	<input type="checkbox"/> 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

PRESCRIPTION DRUG BENEFITS: (REQUIRED)**

Tier 1/ Tier 2/ Tier 3 Copayment (once the in-network deductible has been satisfied)

\$7/\$15/\$35 \$10/\$25/\$50 \$15/50%

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

****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 copay 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 Physical Therapy 90 Rider (30 visits standard)

V. S I G N A T U R E

This Addendum forms a part of the Application between the Group and Us. In the event of a conflict between the provisions of this Addendum and the Application, the provisions of this Addendum will prevail. All other terms and conditions of the Application remain in full force and effect. Nothing contained in this Addendum will be held to vary, alter, waive, or extend any of the terms, conditions, provisions or limitations of the Application to which this Addendum is attached, other than as specifically stated herein.

Dated at: _____ on _____

Print Name of Officer, Partner or Proprietor

Signature of Officer, Partner or Proprietor

Witness to Signature

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.*