OXFORD HEALTH PLANS®

A UnitedHealthcare Company

Liberty Plan℠ Direct 30/50
Liberty Plan℠ EPO 25/50
Freedom Plan® Direct HSA $2,850
Freedom Plan® EPO HSA $2000

NY Sole Proprietor Application

Oxford Health Insurance Inc. ▪ *www.oxfordhealth.com*

Mailing Address: 14 Central Park Drive, Hooksett, NH 03106 **Attn:** Group Enrollment Department

I. GENERAL INFORMATION

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

2. **Primary Address of Group:**
(Street Address
City, State, ZIP Code)
***No P.O. Box**

3. **Plan Administrator/Contact:**

a. Name

b. Title

c. Address
(If different from primary)

City, State, ZIP Code

d. Phone Number Ext.

e. Fax Number

f. E-mail Address

g. Add'l Contact & Number

4. **Name and title of person to receive billing statements:**

a. Name

b. Title

c. Address
(If different from primary)

City, State, ZIP Code

d. Phone Number Ext.

e. Fax Number

5. **Nature of Business:**

6. **SIC Code:**

7. **Tax Identification Number:**

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: _____.
   (Month / Day 1st / Year)
2. **Age of Business:** Please indicate if your business has been in operation: .❑ Less than 12 months ❑ More than 12 months
3. **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

Eligibility & Termination: The employee will become eligible on the latter of the effective date of this plan or the date selected below (check appropriate date).

4. **Integration with Medicare Benefits:** Health benefits covered by Medicare Part A and B are carved out for retired employees age 65 and over and their dependents age 65 and over if the group offers retiree coverage.

III. PRODUCT AND PLAN DESIGNS

A. Oxford Sole Proprietor Plan

Instructions: Please select a plan option and check off any variable items as provided below.

	Liberty Network		Freedom Network	
Benefit Package	**Plan 1 ❑**	**Plan 2 ❑**	**Plan 3 ❑**	**Plan 4 ❑**
Product	Direct	EPO	Direct HSA	EPO HSA
PCP Copayment	30/50	25/50	N/A	N/A
In-Network Coinsurance %	80%	90%	90%	100%
Out-of-Network Coinsurance %	60%	N/A	70%	N/A
In-Network Single Deductible	$2,000	$2,000	$2,850	$2,000
Out-of-Network Single Deductible	$2,000	N/A	$2,850	N/A
Family Multiplier	2x	2x	2x	2x
Emergency Room Copayment	$100	$75	Deductible and Coinsurance	Deductible and Coinsurance
Prescription Benefit	15/50% with $100 deductible		15/50% with $2,850 deductible	15/50% with $2,000 deductible
Inpatient/Outpatient Facility	Deductible and Coinsurance			
Outpatient Surgical	Deductible and Coinsurance			
Domestic Partner	Same and Opposite			

B. Other Riders

❑ Biologically Based Mental Health Services
(30 Days Inpatient Care Per Calendar Year)
(20 Visits Outpatient Care Per Calendar Year)

IV. RATE INFORMATION

Monthly Rates: All new groups are subject to the four-tier rate structure indicated below. Rates must be included in the spaces below for application processing. Please note

V. BROKER/AGENT INFORMATION

	Broker	Co-Broker	General Agent
1. **Name of Broker/Agent :**			
2. **Oxford Broker Code** (*Required*):			
3. **Social Security # or Federal Tax ID #:**			
4. **Broker Street Address:**			
5. **City, State, ZIP Code:**			
6. **Telephone Number:**			
7. **Fax Number:**			
8. **E-mail Address:**			
9. **Commission Split %:**			
10. **Oxford Sales Representative:**	Amy Bisson-NHSBU		
Comments:			

VI. CONSENT

AUTHORIZATION FOR BROKER TO ACT AS BENEFITS ADMINISTRATOR

The undersigned hereby requests Oxford Health Plans 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 Oxford Health Plan 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).

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 _____.
(Month / Day 1st / Year)

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 Oxford 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. COBRA & EXTENSION OF BENEFITS DATA

❒ ❒

❒ ❒

VIII. APPLICANT AGREEMENT