

Name of Company _____

8. Nature of business: [Grid of 20 columns and 2 rows]

9. SIC Code filed with the State of CT: [Grid of 4 columns]

10. Type of Organization: Corporation Partnership Proprietorship LLC Other _____

11. Tax identification Code or Number:
a. Federal I.D. _____
b. State Tax I.D. _____

12. Is your group subject to:
a. COBRA (20+ lives)? Yes No
b. State Continuation (<20 lives)? Yes No

13. Did your group employ at least 1 but no more than 50 employees for at least 50% of your business days during the preceding 12 months? Yes No

II. ADMINISTRATIVE INFORMATION

The term "coverage" refers to the benefits provided by Oxford, pursuant to the Group Certificate.

- 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 which is still in force or that which has terminated within the past three (3) years.

Table with 4 columns: Type of coverage, Name of carrier, Effective date, If terminated, date terminated. Contains 3 empty rows.

4. Employer Contributions: Toward Employee Premium: _____%
Toward Family Premium: _____%

5. Eligibility and Termination: Each employee must be eligible on the date the insurance provided under the Certificate becomes effective with respect to him/her. If the employee is not eligible for coverage on the date the Certificate 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 _____.

Name of Company _____

Defining Eligible Employees (continued)

Retired Employees: Covered Not Covered

The definition of a Retired Employee is:

- an employee who is retired and on pension by the employer.
- an employee who is retired and 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 & 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 first day of the calendar month coinciding with or next following the date on which the employee completes the group specified length of continuous service.

CLASS I

Definition of Class I _____

i) Eligibility

- Date on which 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 next following the date on which the employee completes:
* _____ month(s) of continuous service, or
* _____ days of continuous service.

Termination

- On the last day of the calendar month in which 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

v) Dependent Cut-Off

- End of Semester
- End of Calendar Year
- Other (requires Home Office approval)

CLASS II

Definition of Class II _____

i) Eligibility

- Date on which 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 next following the date on which the employee completes:
* _____ month(s) of continuous service, or
* _____ days of continuous service.

Termination

- On the last day of the calendar month in which 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

v) Dependent Cut-Off

- End of Semester
- End of Calendar Year
- Other (requires Home Office approval)

Name of Company _____

6. Number of Total Employees the Effective Date:

Full-time Employees _____ Part-time Employees _____ Retired Employees _____

Of the Total employees: How many are active eligible full-time employees who work in CT? _____

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; and
- any child;
 - who has not reached age 19 or the limiting age; and
 - who is not married; and
 - who is chiefly dependent upon the employee for support.

The term “child” refers to the employee’s children, including any legal stepchild, legally or proposed adoptive child who is physically placed in subscribers home, or child for whom the employee or employee’s spouse is the court appointed legal guardian.

If a child is a registered full-time student at a university, college, or similar institution of higher learning, then that child will be covered until the earlier of:

- no longer being a registered full-time student:
- reaching the age of: 23 (standard) or 25 (non-standard, additional cost) **(select one)**

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 Health Plans 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 for a complete list of exclusions and limitations.

III. PRODUCT / PLAN DESIGN

SECTION 1: CT Blue Ribbon, Freedom Plan, Freedom Plan Select, HMO and HMO Select

1. Please select a plan type and a plan number (if applicable):

CT Blue Ribbon Plan Design

- | | |
|---|---|
| 1. Office copayment | \$10 |
| 2. Inpatient Facility copayment | \$500 Per Admission not to exceed 50% of the charge for the services provided |
| 3. Skilled Nursing Facility copayment | \$500 Per Admission not to exceed 50% of the charge for the services provided |
| 4. Emergency Room copayment | \$25 |
| 5. Durable Medical Equipment copayment | \$400 Per Item |
| 6. Prosthesis copayment | \$400 Per Item, waived for internal prosthesis |
| 7. Physical Therapy limit | 30 Visits per prescribed course of treatment |
| 8. Pharmacy (includes Contraceptives) | |
| a. Generic/Brand copayment | \$5 |
| b. Limit | \$1,000 |
| 9. Dependent age cutoff | 19/23 |
| 10. Out-of-pocket for covered services | \$1,500 single / \$3,000 family |

Please Note: If CT Blue Ribbon Plan Design was selected, the following options are not available.

Name of Company _____

SECTION 2: HMO Laurel, HMO Laurel Select, Freedom Plan Laurel, Freedom Plan and Laurel Select

1. Please select a plan type and a plan design:

HMO Laurel

HMO Laurel Select

(Deductibles and Out-of-Pocket Accumulation Periods are on a Calendar Year basis.)

| | | | |
|---|-----------------------------|------------------------------|-----------------------------|
| Options: | <input type="checkbox"/> A. | <input type="checkbox"/> E. | <input type="checkbox"/> F. |
| Plan Type: | HMO | HMO | HMO |
| Office Copayment (PCP/Specialist): | \$30/\$45 | \$15/\$25 | \$25/\$40 |
| Single/Family Deductible: | N/A | N/A | N/A |
| Coinsurance: | N/A | N/A | N/A |
| Hospital Copayment: (up to \$2,000/calendar year) | \$500/day | \$100/continuous confinement | \$250/day |
| Outpatient Surgery Copayment: | \$250 | \$50 | \$100 |
| Emergency Room Copayment: | \$150 | \$75 | \$100 |

For prescription and additional riders please see the following page.

Freedom Plan Laurel

Freedom Plan Laurel Select

(Deductibles and Out-of-pocket Accumulation Periods are on a Calendar Year basis.)

| | | | |
|------------------------------------|---|---|---|
| Options: | <input type="checkbox"/> B. | <input type="checkbox"/> C. | <input type="checkbox"/> D. |
| Plan Type: | POS | POS | POS |
| Office Copayment (PCP/Specialist): | \$15/\$25 | \$25/\$40 | \$30/\$45 |
| Out-of-network Deductibles: | | | |
| Single: | \$1,000 | \$1,000 | \$2,500 |
| Family: | \$3,000 | \$3,000 | \$7,500 |
| Out-of-network Coinsurance: | 70% | 70% | 70% |
| Single Coinsurance Maximum: | \$10,000 | \$15,000 | \$20,000 |
| In-network Hospital Copayment: | \$100 per admission (up to \$2,000 per calendar year) | \$250 per day (up to \$2,000 per calendar year) | \$500 per day (up to \$2,000 per calendar year) |
| Outpatient Surgery Copayment: | \$50 | \$100 | \$250 |
| Emergency Room Copayment: | \$75 | \$100 | \$150 |

For prescription and additional riders please see the following page.

V. COBRA & EXTENSION OF BENEFITS DATA

- Are there any employees or dependents of employees who are covered under COBRA or State Continuation on your current plan? Yes No
If yes, identify the number of individuals _____
- Are there any employees or 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. BROKER / AGENT INFORMATION

| | BROKER | GENERAL AGENT |
|--|---------------------|---------------------|
| 1. Full legal name of firm: | _____ | _____ |
| 2. Address of firm: | _____ | _____ |
| 3. Contact: | _____ | _____ |
| 4. Telephone/Fax Number: | _____ | _____ |
| 5. Social Security # or Fed. Tax ID #: | _____ | _____ |
| 6. Broker and/or Agent ID Number: | _____ | _____ |
| 7. Broker and/or Agent Commission %: | _____ | _____ |
| 8. Account Executive: | _____ | _____ |
| | Field Office: _____ | Phone Number: _____ |

VII. 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 acknowledges that the Effective Date of Coverage is not guaranteed and is subject to receipt by Oxford of full requirements including completed Family Health Statements for all employees and their dependents enrolling for coverage. The Applicant hereby confirms that it will not cancel any current health coverage it 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.

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

X

Signature of Authorized Officer of the Applicant

Title of Officer of Applicant

X

Witness

Duly Licensed and Appointed Producer*

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