UnitedHealthcare®
Oxford

Healthy NY Small Employer Group Application

INSTRUCTIONS

Healthy NY brings affordable comprehensive health insurance coverage to those who need it most. Small employers, sole proprietors and individuals meeting certain eligibility criteria may purchase Healthy NY. Please note that individuals and sole proprietors wishing to purchase Healthy NY must complete a different application. Please see the Healthy NY Consumer Guide or log on to www.HealthyNY.com for a full description of the Healthy NY eligibility requirements. You may obtain a consumer guide by calling 1-866-HealthyNY (1-866-432-5849).

Confidentiality Statement All of the information provided on this application will remain confidential. Only the health plans and state agencies which need to determine if your business is eligible to purchase Healthy NY will see this information.

COVERAGE OPTIONS

Benefit Options

Healthy NY offers a standardized benefit package with an optional limited prescription benefit. Choose if you want Healthy NY with or without a prescription drug benefit. Once you choose whether or not you want prescription drug coverage, you will not be able to change your selection until your annual recertification or if your premium rate changes.

Deductible

If you are a newly enrolled Healthy NY Member, you will be enrolled in a High Deductible Health Plan. A High Deductible Health Plan (HDHP) is designed to be used with a health savings account (HSA). This is a savings account used to pay for qualified medical expenses. Contributions are tax-deductible, and money in the account can earn interest tax-free. You can contribute up to $3,100* for individual coverage and $6,250* for family coverage into the account in 2012.

The deductible is $1,200* for individuals and $2,400* for families (more than one person). Copayments do not apply towards the deductible.

*These amounts may be increased in accordance with Federal Government annual increases.

SECTION A. SMALL EMPLOYER INFORMATION

List your company's name and street address. Please indicate the desired effective date of the plan and the Federal Tax Identification number of the Company. Please list the rates for all four tiers if applicable to your company. For example: Single, Employee/Spouse, Employee/Children, and Family. Note that your company's response must be received by or before the 20th of the month for coverage to be effective on the first of the following month. Premium rates will be supplied to the group at the time of enrollment.

SECTION B. HEALTH INSURANCE INFORMATION

Healthy NY is a program for uninsured businesses. It is available to small employers that have not provided comprehensive health insurance to their employees during the past 12 months. However, your business may still qualify if:

- Your business provided only "limited" health insurance benefits.
- Your business "arranged for" group health insurance coverage, but did not contribute more than:
  - $75 per employee per month towards the premium. (If your business is situsted in the following counties: Bronx, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk) or
  - $50 per employee per month towards the premium. (If your business is situsted in Dutchess, Sullivan or Ulster counties.)

Please fully complete the questions in Section B regarding prior health insurance coverage.

SECTION C. ELIGIBILITY REQUIREMENTS

Your business must meet certain eligibility requirements designed to target those most in need of assistance. For example:

- You must have 50 or fewer employees.
- Thirty percent of your employees must earn $40,000 or less annually.
- Your business must contribute 50% of the Healthy NY full-time employee* premium. (*As of 6/1/03 the percentage of your business' contribution for part-time employees is entirely discretionary)

Please note that your business must be able to answer "Yes" to each question in Section C in order to be eligible.

SECTION D. PARTICIPATION REQUIREMENTS

Your business must meet certain participation rules. Please note that your business must be able to answer "Yes" to each question in Section D in order to be eligible.

INSTRUCTIONS (CONT)

SECTION E. EMPLOYEE INFORMATION

Please answer the questions in Section E about who will be offered coverage. Please complete the chart in Section E by providing the names and social security numbers of the employees who will be enrolling in Healthy NY. If necessary, please photocopy the chart and attach additional sheets.

SECTION F. BROKER INFORMATION

Please list broker information if applicable.

SECTION G. HEALTHY NEW YORK PLAN ELECTION

Please select one of the four available benefit options for your employees. You can choose to have coverage with prescription drug coverage or without prescription drug coverage. Also, please select option for Dependent Coverage Extension.

SECTION H. CERTIFICATION

The certification in Section H must be completed by a duly authorized officer of the business.

SECTION I. INTEGRATION WITH MEDICARE BENEFITS

Health benefits covered by Medicare Part A, Part B and Part D are carved out for members age 65 or over.

SUBMITTING YOUR APPLICATION

Please submit this application directly to: **Healthy NY Department, 14 Central Park Drive, Hooksett, NH 03106**. Additional paperwork will be requested if necessary to complete the enrollment process.

UnitedHealthcare®
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Healthy NY Small Employer Group Application

Oxford Health Plans (NY), Inc.

Mailing Address: Healthy NY Department, 14 Central Park Drive, Hooksett, NH 03106
Please see the Healthy NY Consumer Guide, or log onto www.HealthyNY.com for a full description of Healthy NY eligibility requirements. You may obtain a consumer guide by calling 1-866-HealthyNY (1-866-432-5849). Please note that individuals and sole proprietors (someone who is the sole owner and only employee of their business) must complete a different application.

Enter Your Company Name Here			**Date**	
Enter Your Company's Street Address Here				
Enter the City, State, Zip and County				
Telephone Number ( )			**Fax Number** ( )	
Contact Person (For Your Company)		**Title**	**Telephone Number** ( )	
Effective Date		**Tax ID Number**		
Rates	**Single**	**Employee/Spouse**	**Employee/Child(ren)**	**Family**

INFORMATION

Healthy NY is for small businesses which are currently unable to provide their employees with comprehensive health insurance coverage. Healthy NY is generally not available to employers who are already providing their employees with health insurance coverage.

Please answer the following questions to assist us in determining your eligibility to purchase Healthy NY.

1. Within the last twelve months, has your business provided comprehensive group health insurance for your employees? (Answer "Yes" only if the coverage included both medical and hospital coverage)

❑ Yes ❑ No

2. If the answer to question 1 is "Yes", did your business contribute more than $75 per employee per month (for businesses sitused in the Bronx, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland or Suffolk counties) or $50 per employee per month (for businesses sitused in Dutchess, Sullivan or Ulster counties) toward the cost of the health insurance?

❑ Yes ❑ No

SECTION C. ELIGIBILITY REQUIREMENTS

Healthy NY includes certain eligibility requirements designed to reach those small businesses most in need. Please answer the following questions about your business.

Please note that you must be able to check "Yes" to each question in this section in order to be eligible to purchase Healthy NY.

1. Does your business have 50 or fewer employees? ❑ Yes ❑ No

2. Do at least 30% of the employees who will be offered coverage earn annual wages of $40,000 or less? ❑ Yes ❑ No

   a. Will your business contribute at least 50% of the Healthy NY premium on behalf of your full-time employees? ❑ Yes ❑ No

   b. Will your business offer Healthy NY coverage to all employees working 20 hours or more who earn annual wages of $40,000 or less? ❑ Yes ❑ No

SECTION D. PARTICIPATION REQUIREMENTS

Healthy NY has certain employee participation requirements. Please answer these questions about who will be accepting coverage in Healthy NY.

Please note that you must be able to check "Yes" to each question in this section in order to be eligible to purchase Healthy NY.

1. Will at least 50% of the employees who are offered Healthy NY coverage through your business actually accept enrollment or have health insurance coverage through another source? ❑ Yes ❑ No

2. Will at least one employee earning annual wages of $40,000 or less enroll in Healthy NY? ❑ Yes ❑ No

SECTION E. EMPLOYEE INFORMATION

1. Employers may offer Healthy NY coverage to their employee's dependents. Employers are <u>not</u> required to contribute towards the Healthy NY premium for dependents. Will your business be offering Healthy NY coverage to the dependents of your employees?

   ❑ Yes ❑ No

2. Participating employers may choose to offer Healthy NY coverage to part-time workers (those who work less than 20 hours weekly). You do not have to contribute toward the premium for part-time workers. Will your business be offering Healthy NY coverage to part-time workers?

   ❑ Yes ❑ No

3. Employers may offer Healthy NY coverage to their employees' domestic partners. Will your business be offering Healthy NY coverage to the domestic partners of your employees?

   ❑ Yes ❑ No

SECTION E. EMPLOYEE INFORMATION (CONTINUED)

Complete the following by printing or typing the requested information for each employee who is applying for coverage. Please photocopy and attach additional sheets, as needed.

Employee Name (First, MI, Last)	Male or Female	Social Security Number	Is this employee Eligible for Medicare? (Yes or No)

SECTION F. BROKER/AGENT INFORMATION

	Broker	Co-Broker	General Agent
1. Name of Payee:			
2. Payee's Oxford Broker Code (Required):			
3. Payee's Social Security # or Federal Tax ID # :			
4. Name of Writing Agent (Required if Payee is a company):			
5. Writing Agent's Oxford Broker Code (Required if Payee is a company):			
6. Commission Split % :			
7. Sales Representative:			
Comments:			

***Important Information Regarding Producer Compensation:**

We pay brokers and agents (referred to collectively as "producers") compensation for their services in connection with the sale of our insured products in compliance with applicable law. We pay "base commissions" based on factors such as product type, amount of premium, group size and number of employees. These commissions are reflected in the premium rate. Note: All commissions will be uniformly paid among all small group cases. In addition, we may pay bonuses pursuant to bonus programs established from time to time which are designed to provide incentives to achieve production targets, persistency levels, growth goals or other objectives. Bonuses are not reflected in the premium rate but are paid from our general administrative expenses. It is our policy not to pay commissions to producers with respect to a product for which the customer is also paying the producer a commission or other fee. Please note we also may make payments from time to time to producers for services other than those relating to the sale of policies (for example, compensation for services as a general agent or as a consultant). Producer compensation is subject to disclosure of Schedule A of the ERISA Form 5500 for customers governed by ERISA and subject to form 5500 filing requirements. We have also taken steps to ensure that producers properly disclose their compensation arrangements to their customers, but we cannot guarantee the producer's compliance. For general information on our producer payment arrangements, please go to **www.oxfordhealth.com**. For specific information about the compensation payable with **respect to your particular policy, please contact your producer.**

SECTION G. HEALTHY NY PLAN ELECTION

Plan Elections:

Please elect one of the four (4) available Healthy NY plans:

A. Healthy NY with prescription drug coverage**	❑ Yes
B. Healthy NY without prescription drug coverage**	❑ Yes
C. Healthy NY HDHP with prescription drug coverage	❑ Yes
D. Healthy NY HDHP without prescription drug coverage	❑ Yes

** This option is only available for Oxford Health Plan Healthy NY Members enrolled prior to January 1, 2012 with no break in coverage.

Additional Benefit Options:

❑ None

❑ Dependent Coverage Extension through age 29

Important: The benefit package is chosen by the employer and shall apply to all the employees enrolled in the group. The premiums are different for each benefit package. Your election may only be changed upon annual renewal/recertification or upon a rate change.

SECTION H. CERTIFICATION

By signing this certification of eligibility, I certify under penalty of perjury that all statements contained in this application are true and accurate to the best of my knowledge. I further certify that I am an officer of the business and duly authorized to execute this certification on behalf of the business.

I understand that any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Important!

Please Note: A pre-existing condition is any physical or mental condition for which medical advice, diagnosis, care, or treatment was recommended or received within the last six months. Your Healthy NY policy will exclude coverage for that condition for **up to 12 months**. However, this period may be **reduced or eliminated** if you are transferring from other health insurance coverage which terminated no more than **63 days** prior to the date that you submit your Healthy NY application.

As of 6/1/03, individuals who are eligible for a federal tax credit for payment of health insurance premiums, pursuant to the federal Tax Adjustment Act of 2002, and have three months of creditable coverage prior to the enrollment date with no break of coverage greater than 63 days shall not be subject to a pre-existing condition waiting period. Please notify Oxford by providing a certificate of eligibility with your application.

Please review your Healthy NY health insurance policy or contact **Oxford** for a full explanation of exactly what constitutes a pre-existing condition and how this restriction will affect you.

This application should be forwarded directly to Oxford. To submit this application directly, please mail it to Healthy NY Department, 14 Central Park Drive, Hooksett, NH 03106.

_____
Print name of officer completing certification

_____
Signature

_____
Title

_____
Date

UnitedHealthcare®
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Healthy NY Application for Individuals and Sole Proprietors

INSTRUCTIONS

Please note that small group employers wishing to purchase Healthy NY must complete a different application.

Please see the Healthy NY Consumer Guide or log on to www.HealthyNY.com for a full description of the Healthy NY eligibility requirements. You may obtain a consumer guide by calling 1-866-HealthyNY (1-866-432-5849).

Confidentiality Statement. All of the information you provide on this application will remain confidential. The only people who will see this information are the health plans and state agencies who need to determine if you are eligible to purchase Healthy NY.

COVERAGE OPTIONS

Benefit Options

Healthy NY offers a standardized benefit package with an optional limited prescription benefit. Choose if you want Healthy NY with or without a prescription drug benefit. Once you choose whether or not you want prescription drug coverage, you will not be able to change your selection until your annual recertification or if your premium rate changes.

Deductible

If you are a newly enrolled Healthy NY Member, you will be enrolled in a High Deductible Health Plan. A High Deductible Health Plan (HDHP) is designed to be used with a health savings account (HSA). This is a savings account used to pay for qualified medical expenses. Contributions are tax-deductible, and money in the account can earn interest tax-free. You can contribute up to $3,100* for individual coverage and $6,250* for family coverage into the account in 2012.

The deductible is $1,200* for individuals and $2,400* for families (more than one person). Copayments do not apply towards the deductible.

*These amounts may be increased in accordance with Federal Government annual increases.

SECTION A. APPLICANT INFORMATION

In this section, we ask how to contact you. Please list your home address and your mailing address, if different. **Note that your response must be received by or before the 20th of the month for coverage to be effective on the first of the following month.**

SECTION B. EMPLOYMENT INFORMATION

You can qualify for Healthy NY if you worked during the past 12 months. If you have not worked in the past 12 months, you can still qualify if your spouse was employed during the past 12 months. Please answer the questions in Section B about employment.

SECTION C. INSURANCE INFORMATION

Healthy NY is available to those who have been without health insurance for 12 months and those who have lost their health insurance due to qualifying reasons. Some qualifying reasons include loss of health insurance coverage due to job loss, divorce or separation, death of a spouse, and change in residence. Please fully complete the questions in Section C regarding prior health insurance coverage. Please note that cancelling other insurance due to cost is not a qualifying reason.

SECTION D. HOUSEHOLD INCOME

In order to qualify for Healthy NY, your household income must fall within the limits established for the program. Please list your current gross monthly income and the current gross monthly income of your spouse (if residing in your household) in the space provided in Section D. No one else's income is counted.

Please include wages, salary, self-employment income, interest and dividends, social security income, retirement income, alimony, unemployment benefits and workers' compensation. Please do not include public assistance, supplemental security income (SSI), foster care payments or child support payments you receive.

INSTRUCTIONS (CONT)

SECTION E. HOUSEHOLD MEMBERS

Please fully complete the chart in Section E. Include information regarding yourself, your spouse, your domestic partner (if you are a sole proprietor) and your children. Spouses and domestic partners must reside in your household. Please include information on each of these individuals even if you do not wish to purchase Healthy NY coverage for them.

The Healthy NY income limitations vary for households of different sizes. Refer to the chart below to determine if you meet the Healthy NY household income requirements. For those applying for coverage, please provide the name of the primary care physician chosen, if known.

Family Size	Monthly Household Income
1	Up to $2,269*
2	Up to $3,065*
3	Up to $3,861*
4	Up to $4,657*
5	Up to $5,453*
6	Up to $6,248*
Each Additional:	Add $796*

*These amounts may be increased in accordance with NY Department annual increases.

Amounts effective 1/1/12.

Pregnant women count as two people.

SECTION F. DOCUMENTATION

Please review Section F. Documentation of New York State residence, employment status and household income must be included with your application.

SECTION G. HEALTHY NY PLAN ELECTION

Please select whether you want Healthy NY with prescription drug coverage or without prescription drug coverage. Also, please select option for Dependent Coverage Extension.

SECTION H. CERTIFICATION

Please review and complete the certification set forth in Section H. If you are eligible for the Federal Tax Adjustment Act of 2002, a certificate of eligibility must be included with your application.

SUBMITTING YOUR APPLICATION

Your last step in applying for Healthy NY is to submit your application directly to Oxford.

To submit this application, please mail it directly to: **Healthy NY Department, 14 Central Park Drive, Hooksett, NH 03106** Additional paperwork will be requested if necessary to complete the enrollment process.

DON'T FORGET!

- **Sign your application!**
- **Enclose proof of applicant's address!**
- **Enclose first month's premium!**

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Healthy NY Application for Individuals and Sole Proprietors - HMO

Oxford Health Plans (NY), Inc.

Mailing Address: Healthy NY Department, 14 Central Park Drive, Hooksett, NH 03106

Please see the Healthy NY Consumer Guide or log on to **www.HealthyNY.com** for a full description of the Healthy NY eligibility requirements. You may obtain a consumer guide by calling 1-866-HealthyNY (1-866-432-5849).

SECTION A. APPLICANT INFORMATION

Name First	Middle Initial	Last	
Telephone Number Home ( )	Work ( )		
Address of Person Applying for Coverage Street			
City	State	Zip	County
Mailing Address (if different than above) Street			
City	State	Zip	County
Requested Effective Date ___/ 01 /___ Month / Day / Year			

SECTION B. EMPLOYMENT INFORMATION

1. Please indicate whether you are applying as an individual or as a sole proprietor. A sole proprietor is someone who is the sole owner and only employee of a business.

   ❑ Individual
   ❑ Sole Proprietor

Note to sole proprietors only: Sole proprietors may offer Healthy NY coverage to their domestic partner. Will your business be offering Healthy NY coverage to a domestic partner?

❑ Yes ❑ No

2. You can qualify for Healthy NY if you or your spouse worked during the past 12 months. Please answer the following questions about employment.

Currently employed:	❑ You	❑ Your spouse	❑ Neither
Worked in the past year:	❑ You	❑ Your spouse	❑ Neither

If both questions are answered “Neither”, you will not qualify for Healthy NY.

SECTION C. HEALTH INSURANCE INFORMATION

Healthy NY is available to individuals who have not had comprehensive health insurance coverage in place during the past 12 months OR have lost their insurance due to certain reasons. Please answer the following questions to assist us in determining your eligibility.

1. Have you had health insurance coverage which included both medical and hospital benefits during the past twelve months? (Note: Answer "No" if your coverage was through Medicaid, Child Health Plus, Family Health Plus, Healthy NY or another public program or if you had COBRA coverage.)

   ❑ Yes
   ❑ No

2. If you have had comprehensive health insurance coverage during the past twelve months, did it terminate for one of the following reasons? (Please check all that apply.)

   ❑ Loss of employment
   ❑ Change to a new employer
   ❑ Change of residence
   ❑ Death of a family member
   ❑ Legal separation, divorce or annulment
   ❑ Reached the maximum age under your policy
   ❑ Loss of eligibility for group health insurance coverage
   ❑ Discontinuation of a group health insurance plan
   ❑ Termination or cancellation of COBRA/continuation coverage

3. Date coverage terminated or will terminate due to reason noted in 2. _____/_____/_____

4. What kind of coverage do you want?

   ❑ Single
   ❑ Family
   ❑ Husband and Wife
   ❑ Parent and Child(ren)

5. Integration with Medicare Benefits: Health Benefits covered by Medicare Part A, Part B and Part D are carved out for members age 65 or over.

SECTION D. HOUSEHOLD INCOME

Please list your current monthly gross income and the current monthly gross income of your spouse (if residing in your household). Please include wages, salary, interest and dividends, self-employment income, social security income, retirement income, alimony, unemployment benefits and workers' compensation. Please **do not** include public assistance, supplemental security income (SSI), foster care payments or child support received.

Applicant's Current Monthly Gross Income	$
Spouse's Current Monthly Gross Income	$
Total	$

(Please Note: Sole proprietors should deduct their monthly business expenses in calculating their monthly income.)

SECTION E. HOUSEHOLD MEMBERS

The household income limitation depends upon the number of household members that you have. Household members include yourself, your spouse (if residing in your household) and dependent children. For each person listed, please indicate whether that person is applying for coverage. Please note that sole proprietors may include a domestic partner as a spouse if you wish to cover them under your policy. Fill in the name of the primary care physician (PCP) chosen by each person to be covered, if known.

Applicant's Name	Male/ Female	Date of Birth	Applying for Coverage?	Social Security #	Eligible for Medicare?	PCP Oxford ID#/Name
(First, MI, Last)	❑ M ❑ F		❑ Yes ❑ No		❑ Yes ❑ No	
Spouse or Domestic Partner						
(First, MI, Last)	❑ M ❑ F		❑ Yes ❑ No		❑ Yes ❑ No	
Child's Name						
(First, MI, Last)	❑ M ❑ F		❑ Yes ❑ No		❑ Yes ❑ No	
Child's Name						
(First, MI, Last)	❑ M ❑ F		❑ Yes ❑ No		❑ Yes ❑ No	
Child's Name						
(First, MI, Last)	❑ M ❑ F		❑ Yes ❑ No		❑ Yes ❑ No	
Child's Name						
(First, MI, Last)	❑ M ❑ F		❑ Yes ❑ No		❑ Yes ❑ No	

Pregnant women count as two people for determining household size.
Are any of the household members listed above pregnant? ❑ No ❑ Yes (Who? _____)

SECTION F. DOCUMENTATION

IMPORTANT! You **must** attach documentation of **New York State residence**, your **employment status** and your **household income**. Please include at least one from each category. If this information is not available or not representative of your typical income, please submit your tax return or business documentation and explanation of the documents. The following are examples of acceptable documentation:

New York State Residence	Employment Status	Income
❑ New York State driver's license	❑ Pay stubs	❑ Letter from employer
❑ Utility bill (gas, electric, cable) or postmarked mail with address	❑ Letter from employer	❑ Pay stubs
❑ Letter/lease/rent receipt with home address from landlord	❑ Documentation sufficient to demonstrate self-employment	❑ Business Records
❑ Property Tax Records or Mortgage Statement	❑ Other (please explain): _____	❑ Award letters/benefit checks
❑ Other (please explain):		❑ Other (please explain): _____

Note: Individuals who are transferring from New York's Voucher Insurance Program or the New York State Health Insurance Partnership Program should attach proof of participation in these programs in lieu of the documentation listed above.

SECTION G. HEALTHY NY PLAN ELECTION

Plan Elections:

Please elect one of the four (4) available Healthy NY plans:

A. Healthy NY with prescription drug coverage** ❑ Yes
B. Healthy NY without prescription drug coverage** ❑ Yes
C. Healthy NY HDHP prescription drug coverage ❑ Yes
D. Healthy NY HDHP without prescription drug coverage ❑ Yes

** This option is only available for Oxford Health Plan Healthy NY Members enrolled prior to January 1, 2012 with no break in coverage.

Additional Benefit Options:

❑ Dependent Coverage Extension through age 29
❑ None

Important: Your election may only be changed upon annual renewal/recertification or upon a change in rates. Your renewal or recertification occurs annually when you are required to complete the Recertification of Coverage documentation.

SECTION H. CERTIFICATION

By signing this certification of eligibility, I certify under penalty of perjury that all statements contained in this certification are true to the best of my knowledge. I further certify that I am ineligible for health insurance provided by my employer and all individuals to be covered are ineligible for Medicare.

I understand that any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Important!

Please Note: A pre-existing condition is any physical or mental condition for which medical advice, diagnosis, care, or treatment was recommended or received with the last six months. Your Healthy NY policy will exclude coverage for that condition for **up to 12 months**. However, this period may be **reduced or eliminated** if you are transferring from other health insurance coverage which terminated no more than **63 days** prior to the date that you submit your Healthy NY application. Note: This provision does not include children under the age of 19.

As of 6/1/03, individuals who are eligible for a federal tax credit for payment of health insurance premiums, pursuant to the federal Tax Adjustment Act of 2002, and have three months of creditable coverage prior to the enrollment date with no break of coverage greater than 63 days shall not be subject to a pre-existing condition waiting period. Please notify Oxford by providing a certificate of eligibility with your application.

Please review your Healthy NY health insurance policy or contact **Oxford** for a full explanation of exactly what constitutes a pre-existing condition and how this restriction will affect you.

This application should be forwarded directly to Oxford. To submit this application, please mail it to:

Healthy NY Department
14 Central Park Drive
Hooksett, NH 03106

Signature _____ Date _____

Oxford Health Plans (NY), Inc.
Healthy New York
Oxford Group Enrollment Agreement

Group Name:_____ ("Group")

Group Numbers: _____ Effective Date: _____ , ____.

Definitions

- Agreement: This Group Enrollment Agreement, the Group Application, the individual applications of the Members, the Certificate of Coverage and Member Handbook, the Summary of Benefits and any applicable Riders.

- OHPNY, Us , We, Our: Oxford Health Plans (NY), Inc.

- Members: Subscribers [1][and Covered Dependents].

- Terms not defined in this Group Enrollment Agreement will have the meaning set forth in the Certificate.

In consideration of the payment of Premiums, OHPNY and Group agree that OHPNY will arrange or pay for Covered medical and hospital services in accordance with the terms and provisions of the Agreement. Such services will be provided for the Group's eligible employees (Subscribers) [2][and their Covered Dependents].

I. EFFECTIVE DATE AND TERMS OF AGREEMENT:

The Agreement will be effective on the _____ day of _____, _____ at 12:00 a.m. Eastern Time and will remain in effect for a period of ____ consecutive months, ending on the ___ day of ____, _____ at 11:59 p.m. Eastern Time at which time coverage will terminate (the "Initial Contract Period"). The Agreement, and the coverage provided under the Agreement, will automatically renew after the end of the Initial Contract Period or any Subsequent Contract Period unless it would otherwise terminate in accordance with Section XIII of this Group Enrollment Agreement.

II. COVERAGE:

Benefit Plan Code/Description: _____

Optional Benefit Rider:

III. PREMIUM RATE SCHEDULE:

Type of Coverage	Total Monthly Premium
_____ Single _____	$ _____
_____ Family _____	$ _____
_____ Parent/Child [ren] __	$ _____
_____ Couple _____	$ _____

IV. ELIGIBILITY GUIDELINES:

A. Small Employer Eligibility

To be considered an Eligible Small Employer to offer Healthy New York all of the following criteria must be met by the Group:

- The small business must be located within New York State,
- The small employer must have 50 or fewer eligible employees.
- [3][30%] of the eligible employees must earn wages of [4][$34,000] or less annually.
- The small employer must contribute [5][at least 50%] of the Healthy New York full time employee premium (the percentage of the small employer's contribution for part-time employees is entirely discretionary)
- The small employer must not have provided group health insurance coverage to its employees within the preceding 12 months. Previous coverage does not include: (i) coverage that offered limited benefits, i.e. medical benefits only or hospital benefits only or (ii) coverage "arranged for" by the Group if the Group contributed [6] [$50 or less] (or [7] [$75 or less] if the business is located in Bronx, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, and Westchester counties) towards the premium.
- [8][Fifty percent (50%)] of the eligible employees, who are not otherwise insured, must participate in the program and at least one participant must earn annual wages of [9][$34,000] or less.
- At least one eligible employee (Subscriber) [10] earning annual wages of [$34,000] or less must enroll in Healthy New York.

B. Subscriber Eligibility

Eligible employees of the Group will be employees of the Group who work a minimum of [11][**20** hours per week] who earn [12][$34,000 or less] annually [13][and part-time employees who work [14][**20** hours or less per week].] In addition, eligible employees of the Group and their eligible family members will meet the eligibility criteria set forth in the Certificate and the requirements set forth below:

Subscribers: Subscribers will be eligible on the [15][first day of month] occurring [16][30 days] after commencement of employment. Coverage ends on the [17][last day of the month in which eligibility ends].

[18][Such waiting period is waived for employees rehired within [19][six] months after an approved leave of absence.]

[20][Covered Dependents: The legal spouse of the Subscriber and any unmarried, dependent children, as defined in the Certificate, are eligible for coverage. Such children are eligible only until the child reaches age 19 or age 23 if child is full-time student. Coverage ends on the last day of the month in which child's birthday occurs.

Handicapped dependents: The attainment of the limiting age for dependent children shall not operate to terminate the coverage of the child if at such date the child is and continues thereafter to be both (1) incapable of self-sustaining employment by reason of mental or physical handicap and (2) chiefly dependent upon such employee or Subscriber for support and maintenance.

Proof of the incapacity and dependency shall be furnished by the employee or Subscriber within thirty-one days of the child's attainment of the limiting age. Periodic proof may be required, but in no case more frequently than once a year.

Adopted children: Coverage shall be provided for children legally placed for adoption with an employee or other Subscriber of the Group who is an adoptive parent or prospective adoptive parent, even though the adoption has not been finalized, provided the child is dependent upon such employee or Subscriber for support and maintenance.

The Group may require notification of the acceptance of the child within thirty-one days after the acceptance of such child in order to continue coverage.]

The eligibility requirements listed in this section of this Group Enrollment Agreement are material to Our administration of the Agreement. During the term of the Agreement, We will not permit any change in these eligibility requirements unless We agree, in writing, to such change.

V. NOTICE:

[21][All notices to be given to the Group Broker will be addressed to:

_____
_____
_____
attn:_____]

All notices to be given to the Group will be addressed to:

_____
_____
_____
attn:_____

All notices to be given to Us will be addressed to:

Oxford Health Plans (NY), Inc.
[22][521 Fifth Avenue
New York, NY 10175]

VI. PREMIUM DUE DATE AND PAYMENTS:

The first day of the month is the "Premium Due Date." The Group agrees to remit to Us on or before the Premium Due Date the applicable Total Monthly Premium set forth in Section III above for each Subscriber enrolled as of such date. Membership as of such date will be determined by Us in accordance with Our Subscriber records. If a Premium payment is not made in full by Group on or prior to the Premium Due Date, a 30-day Grace Period will be granted to the Group for payment without interest charge. If payment is not received by the expiration of the Grace Period, then the Agreement may be terminated by Us pursuant to Section XIII of this document. Premiums outstanding subsequent to the end of the Grace Period will be subject to a late penalty charge of 1.50% of the total Premium amount due. This amount will be calculated for each 30-day period, or portion thereof, that the amount due remains outstanding. If the Agreement is terminated for any reason, the Group will continue to be held liable for all Premium payments due and unpaid before the termination, including, but not limited to, Premium payments for any time the Agreement is in force during the Grace Period.

Notwithstanding any language to the contrary in the Agreement, We will have no obligation to provide benefits or pay claims for any Subscriber during any period for which the required Premium payment has not been made, including during any Grace Period. If We provide benefits or pay claims for any Subscriber during any period for which the Premium payment has not been made, such provision of benefits or payment of claims will not constitute a waiver of Our right to discontinue the provision of coverage or payment of claims until such time as the Premium payment is made.

VII. PREMIUM ADJUSTMENTS:

A. Enrollment. If a Subscriber enrolls on or before the fifteenth (15^{th}) day of a month, the Group will remit to Us on or before the next Premium Due Date an additional Total Monthly Premium for such Subscriber for the month in which the Subscriber enrolled. If a Subscriber enrolls after the fifteenth (15^{th}) day of a month, no additional Premium payment will be due for such Subscriber for the month in which the Subscriber enrolled. Note: This does not apply to any Group where the Subscribers become eligible for coverage on the first day of the month, per Section IV, "Eligibility."

B. Termination. If a Subscriber's coverage ends on or before the fifteenth (15^{th}) day of a month, We will credit the Group the total Monthly Premium for such Subscriber for that month. If a Subscriber's coverage ends after the fifteenth (15^{th}) day of a month, the Group will not be entitled to any Premium adjustment from Us. Note: This does not apply to any Group whose Subscriber's lose coverage on the last day of the month, per Section IV, "Eligibility."

VIII. PREMIUM RATE CHANGES:

Initial Contract Period: The Premium Rate Schedule set forth on page one of this Group Enrollment Agreement will be valid only for the Initial Contract Period. Premium Rates for the Initial Contract Period will not be changed by Us except with a [22][30-day] prior written notice to the Group or unless a change required by statute or regulation increases Our cost risk under the Agreement. If such a statutory or regulatory change occurs, We may change the Premium Rate Schedule at any time with a [23][30-day] prior written notice to Group.

Subsequent Contract Period: At any time, with a [24][30-day] prior written notice, We may change the Premium Rate Schedule for any Subsequent Contract Period as follows:

- Upon a Premium Rate increase under this Agreement;
- Upon the renewal of the Agreement; or
- When a change required by statute or regulation that increases Our risk under the Agreement.

Regarding renewals: If We fail to give the Group the required advance notice, the Premium Rates in effect prior to the commencement of the Subsequent Contract Period will remain in effect for a period of [25][30] days after the Group was notified by Us of the new Premium Rates for the Subsequent Contract Period, after which period the new Premium Rates will go into effect.

IX. SUBSCRIBER EFFECTIVE DATES OF COVERAGE:

Coverage of prospective Subscribers will be subject to Our receipt of an complete and signed Enrollment Form, certification of eligibility and applicable monthly Premium for each prospective Subscriber within 31 days of the Subscriber becoming eligible for coverage under the Agreement.

X. INELIGIBLE SUBSCRIBERS:

If the Group fails to immediately notify Us of a Subscriber's ineligibility, and the Group has made or continues to make the Premium payments for such Subscriber, We will credit such Premium payment back to the last day of the month immediately prior to the month in which such termination notice is received by Us. We will provide this credit only if We have not authorized or incurred claims for health services for such Subscriber during the period when We were unaware of the Subscriber's ineligibility.

XI. OPEN ENROLLMENT PERIOD:

The Group will hold a Group Open Enrollment Period at least once each year. During the Group Open Enrollment Period, eligible employees, as determined by the Agreement, may elect coverage under the Agreement.

XII. RESPONSIBILITIES OF GROUP:

Group agrees to:

A. Offer coverage to those eligible employees [26][and Covered Dependents], as described in Section IV above.

B. Provide notification to each Subscriber, within 15 days after termination of the Subscriber's coverage, of the Subscriber's right to convert to one of Our individual direct payment contracts, contingent upon the Subscriber having reasonable access to Our Service Area or convert to the Healthy New York Individual Program. Group is also responsible for providing COBRA notices to ineligible Subscribers.

C. Furnish to Us, on a monthly basis (or as otherwise required), on Our approved forms, such information as may reasonable be required by Us for the administration of the Agreement, including any change in a Member's eligibility status. In addition, We may, at reasonable times, examine the Group's pertinent records with respect to eligibility and Premium payments hereunder.

D. Comply with all policies and procedures established by Us in administering and interpreting the Agreement. This includes providing Oxford with the Re-certification Notice [27][at least 45] days prior to the renewal date.

XIII. TERMINATION:

A. The Agreement may be terminated by Us:

(i) Upon written notice, if any Premium payment or contribution required to be made by the Group is not received by the Premium Due Date, subject to a 30-day grace period;

(ii) Upon written notice, if the Group ceases to operate or relocates outside of the Service Area;

(iii) If the Group has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the Agreement;

(iv) We cease offering group contracts in New York in accordance with applicable law;

(v) The Group ceases to meet the requirements for a group as defined under applicable law;

(vi) In connection with this Plan, there is no longer any employee who lives, resides or works in the Service Area; or

(vii) For failure to provide Us with Re-certification notice [28][at least 60 days] prior to the renewal date.
Notice of non-renewal will be issued with [29][45 days] notice.

(viii) For such other reasons as are acceptable to the Superintendent of Insurance and not inconsistent with Public Law 104-191.

B. The Agreement may be terminated by the Group:

(i) Upon written notice, in the event of the insolvency or bankruptcy of OHPNY;

(ii) Upon written notice, in the event of the revocation of OHPNY's Certificate of Authority;

(iii) In the event of Our material breach of any of the terms and provisions of the Agreement, upon a 45-day prior written notice to Us;

(iv) As of the date any Premium change would become effective, by providing Us with written notice of termination not less than 30 days prior to such effective date; or

(v) Without cause, by giving Us a [30] [30]-day advance written notice.

XIV. ENTIRE AGREEMENT:

The Agreement constitutes the entire agreement between the parties and supersedes all prior and contemporaneous arrangements, understandings, negotiations and discussions of the parties with respect to the subject matter hereof, whether written or oral; and there are no warrantees, representations, or other agreements between the parties in connection with the subject matter hereof, except as specifically set forth herein. No supplement, modification or waiver of the Agreement will be binding unless executed in writing by authorized representatives of the parties.

XV. APPLICABLE LAW:

The Agreement will be governed by the laws of the State of New York.

XVI. INCONSISTENCY:

In the event of any inconsistency between this Group Enrollment Agreement and the Certificate, the terms of this Group Enrollment Agreement will govern.

XVII. AMENDMENTS:

Any amendments to the Agreement must be in writing and must be approved by authorized representatives of both the Group and OHPNY. No other individual has the authority to modify the Agreement, waive any of its provisions or restrictions, extend the time for making a payment, or bind OHPNY by making any other commitment or representation.

Formal acceptance of an amendment to the Agreement by the Group will not be required if: the change has been negotiated by means of a request by the Group and agreed to by Us and such amendment is attached to this Group Enrollment Agreement; if the change is required to bring the Agreement into conformance with any applicable law, regulation or ruling of the jurisdiction in which the Agreement is delivered or of the federal government; or if the Group makes payment of any applicable Premium on and after the effective date of such amendment.

OXFORD HEALTH PLANS (NY), INC. _____
(Group)

By:_____ By: _____
Authorized Signature *Authorized Signature*

TITLE: _____ TITLE: _____

DATE:_____ DATE: _____

[a] [Attachments: Amendments requested by the Group and accepted by Us.]

Explanation of Variability
Group Enrollment Agreement

[1] This language will be used if dependents are covered.
[2] This language will be used if dependents are covered.
[3] The amount may change if applicable law changes.
[4] The amount may change if applicable law changes.
[5] The amount may change if applicable law changes.
[6] The amount may change if applicable law changes.
[7] The amount may change if applicable law changes.
[8] The amount may change if applicable law changes.
[9] The amount may change if applicable law changes.
[10] This language will be used if dependents are covered.
[11] The correct information will appear if depending on what the employer has elected to offer.
[12] The amount may change if applicable law changes.
[13] This language will be used of Employer's offer coverage to their part time employees.
[14] The correct information will appear if depending on what the employer has elected to offer.
[15] The group will determine when eligibility begins and ends.
[16] The group will determine when eligibility begins and ends.
[17] The group will determine when eligibility begins and ends.
[18] This provision may be used at the employer's discretion.
[19] A shorter time frame may be used at the employer's discretion.
[20] This language will be used if dependents are being covered.
[21] This language will be used if appropriate.
[22] The correct address will appear here.
22 A longer notice period may be used
[23] A longer notice period may be used.
[24] A longer notice period may be used.
[25] The amount of days may be increased.
[26] This language will be used if dependents are being covered.
[27] The amount may change if applicable law changes.
[28] The amount may change if applicable law changes.
[29] The amount may change if applicable law changes.
[30] The amount may change if applicable law changes.

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Healthy New York Member Enrollment Form

Mailing Address: Healthy New York Department, 14 Central Park Drive, Hookset, NH 03106 • 1-800-216-0778

UnitedHealthcare Oxford

THANK YOU FOR CHOOSING AN OXFORD PRODUCT FOR YOU AND YOUR FAMILY.

IMPORTANT:

PLEASE PRINT AND PRESS DOWN FIRMLY WHEN COMPLETING THIS FORM.

IN ORDER TO PROCESS THE ATTACHED FORM AND BEGIN COVERAGE, ALL FIELDS MUST BE COMPLETED ACCURATELY AND IN ITS ENTIRETY.

BE SURE TO:

- Use only blue or black ballpoint pen
- Enter all dates using the MM/DD/YYYY format
- Employer and employee signatures are required
- List any coordinating coverage (coverage in addition to this coverage)
- List any coverage you had prior to this coverage
- Attach disability paperwork, if applicable
- Check “full-time student” in the child column if the child is between the ages of 19-26 and a full-time student at an accredited institution
- Check “young adult” in the child column if the child is under the age of 30, eligible, and enrolling onto the young adult option. The young adult will also need to list their qualifying event, address and signature. Please note: The young adult option creates a new right that allows a young adult or their parent to purchase health insurance through the parent’s group health insurance policy if the young adult does not otherwise qualify as a dependent due to age. There is a separate premium for the young adult option, which the young adult or the young adult’s parents must pay.
- Submit this form within 31 days of the requested effective date or within 60 days of the qualifying event for COBRA or State Continuation

IF YOU HAVE ANY QUESTIONS, PLEASE FEEL FREE TO CALL CUSTOMER SERVICE AT

1-800-216-0778

Healthy New York Member Enrollment Form

UnitedHealthcare® Oxford

Mailing Address: Healthy New York Department, 14 Central Park Drive, Hookset, NH 03106 • 1-800-216-0778

A. Group Information (To be completed by the employer)

Please print neatly using black or blue ballpoint pen • ALL DATES MUST BE: MM/DD/YYYY

Group Number	Group Name	Plan CSP	Billing Group	Date of Hire	Effective Date	Occupation
				/ /	/ /	

☐ On Leave of Absence ☐ Retired
☐ Union Employee ☐ Disabled

COBRA/Young Adult/SC Qualifying Event Date
Event / /

Employer Signature Date
X / /

B. Applicant Details (To be completed by the employee)

	Employee/Subscriber	Spouse	Child	Child
Social Security Number:				
Last Name:				
First Name, Middle Initial:				
Date of Birth: (MM/DD/YYYY)	/ /	/ /	/ /	/ /
Gender and Disability Status: (Check appropriate boxes.)	☐ M ☐ F / ☐ Disabled	☐ M ☐ F / ☐ Disabled	☐ M ☐ F / ☐ Disabled	☐ M ☐ F / ☐ Disabled
Primary Care Physician (PCP) ID Number: PCP Name: (If an existing patient of PCP, check "Yes".)	☐ Yes	☐ Yes	☐ Yes	☐ Yes
Check all that apply:		☐ Domestic Partner	☐ Full-time Student ☐ Young Adult	☐ Full-time Student ☐ Young Adult
Prior Carrier (List coverage prior to this.) ☐ Same for all	Carrier: Policy Number: From Date Thru date::	/ / / /	/ / / /	/ / / /

C. Coordination of Benefits

		Employee/Subscriber	Spouse	Child	Child
Medicare Coverage	Check appropriate box and list effective date:	☐ Part A / / ☐ Part B / / ☐ Part D / /	☐ Part A / / ☐ Part B / / ☐ Part D / /	☐ Part A / / ☐ Part B / / ☐ Part D / /	☐ Part A / / ☐ Part B / / ☐ Part D / /
Pharmacy ☐ Same for all **Effective Date**: / /	Policy Number: Carrier: Policy Holder: Group Number:	BIN: PCN:	BIN: PCN:	BIN: PCN:	BIN: PCN:
Medical ☐ Same for all	Policy Number: Carrier: Policy Holder: Effective Date:	/ /	/ /	/ /	/ /

I understand that my enrollment and benefits are in accordance with those described in the applicable Oxford Health Plans (NY), Inc. HMO Certificate. I understand that, in order to qualify for HMO benefits, I and any enrolled dependents must choose an Oxford affiliated physician for primary care and secure a referral from that physician to an Oxford-affiliated specialist physician for all specialist care. I authorize any health provider or insurer to furnish Oxford Health Plans (NY), Inc. any records concerning me or any enrolled member of my family for whom information is requested. A photographic copy of this authorization shall be valid as the original. I understand that any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation

Employee's/Young Adult's Address (Apt #)

City State Zip

Employee's/Young Adult's Signature Date
X / /

UnitedHealthcare Oxford

Healthy NY Recertification and Plan Selection Form Small Group

Mail To: Healthy NY, Attn: Enrollment, 14 Central Park Drive, Hooksett, NH 03106

A. Group Information				
Group ID Number	Company Name			Phone Number
Address	City	State	Zip Code	
Contact Person	Title	Phone Number	Fax Number	

B. Contribution and Participation Requirements		
1. The Employer contributes at least 50% of the premium on behalf of the employees?	__Yes	__No
2. The business has fifty or fewer eligible employees?	__Yes	__No
3. Half of the employees have coverage via Healthy NY or another source.	__Yes	__No
4. 30% of the employees offered coverage earn $40,000* or less.	__Yes	__No
5. At least one participating employee earns $40,000* or less.	__Yes	__No

C. Plan Selection (Permitted at recertification of in the event of premium change)
Note: HMO Plans are only available to members who presently are enrolled on this plan.

_____	_____	_____	_____
HMO (no pharmacy)	HMO (with pharmacy)	High Deductible (no pharmacy)	High Deductible (with pharmacy)

High Deductible: The deductible is $1,200* for individuals and $2,400* for families (more than one person). Except for preventive care, you must pay for the cost of covered services until you meet the deductible. You can access preventive care before meeting the deductible and may have a co-payment for these services. Co-payments do not apply towards the deductible. Meant to be used with a health savings account. Contributions to the health savings account are tax-deductible, and money in the account can earn interest tax-free. You can contribute up to $3,100* for individual coverage and $6,250* for family coverage into the account. Visit www.HealthyNY.com to learn more about the high deductible option.

Coverage for Dependents through age 29: A Dependent who has attained the above limiting age can continue coverage until they reach age 30, subject to the eligibility requirements as outlined in the Certificate. Please choose one option below:

Dependent Age 29 Extension Benefit ___Yes ___ No

Submission of a completed Add/Term/Change form is required for dependent enrollment.

UnitedHealthcare Oxford

Healthy NY Recertification and Plan Selection Form Small Group

Mail To: Healthy NY, Attn: Enrollment, 14 Central Park Drive, Hooksett, NH 03106

D. Grandfathering and Non-Grandfathering
Please reference the attached Addendum for more information.*

Choose One: I am renewing with changes and/or have decreased my employer contributions by 5% or more _____Yes _____No

Choose One: I am not renewing with changes and/or have not decreased my employer contributions by 5% or more and would like to choose the:_____ Grandfathered Option _____ Non-Grandfathered Option

F. Certification

By signing below, I certify that all statements contained in this form are true and accurate to the best of my knowledge. I further certify that I am an officer or owner of the business and duly authorized to execute this certification on behalf of the business.

_____
Print Name and Title of officer or owner completing certification

_____
Signature Date

Any person who knowingly and with the intent to defraud an insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning an fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

*These amounts may be increased in accordance with Federal Poverty Levels.

UnitedHealthcare
OXFORD

Healthy NY Recertification and Plan Selection Form
Individual and Sole Proprietor

Mail To: Healthy NY, Attn: Enrollment, 14 Central Park Drive, Hooksett, NH 03106

A. Member Information

Social Security Number	Name (First, Middle, Last)		Phone Number
Address (Where you reside)	**City**	**State**	**Zip Code**
Mailing Address (if different from above)			

B. Income Verification (use income chart below to determine eligibility)

Family Size	Current Monthly Gross Income		Monthly Gross Income Allowed (Based on Family Size)	
Please list the total number of members in your household:	Applicant	Spouse	Up to $2,257*	1 person
	$_____	$_____	Up to $3,036*	2
			Up to $3,815*	3
	Total Gross Income		Up to $4,594*	4
			Up to $5,373*	5
_____	$_____		Up to $6,153*	6
			Add $780* per person	Each additional

- Household members include you, your spouse (if residing in your household) and dependent children. Pregnant women count as two people for determining the number of household members.
- Income Includes: wages, salary, interest and dividends, self-employment income, social security income, retirement income, alimony, unemployment benefits and workers compensation. Do not include public assistance, supplemental security income (SSI), foster care payments or child support received

C. Medicare Eligibility (Persons covered under Medicare will lose eligibility for Healthy NY)

Is anyone to be covered under the policy also eligible for Medicare? _____Yes _____No
If yes, please write the name of the person:_____

D. Plan Selection (Changes only permitted at recertification or at time of a rate change)

_____	_____	_____	_____
HMO (no pharmacy)	HMO (with pharmacy)	High Deductible (no pharmacy)	High Deductible (with pharmacy)

High Deductible: The deductible is $1,200* for individuals and $2,400* for families (more than one person). Except for preventive care, you must pay for the cost of covered services until you meet the deductible. You can access preventive care before meeting the deductible and will have a co-payment for these services. Co-payments do not apply towards the deductible. This plan is meant to be used with a health savings account. Contributions to the health savings account are tax-deductible, and money in the account can earn interest tax-free. You can contribute up to $3,050* for individual coverage and $6,150* for family coverage into the account in 2010. Visit www.HealthyNY.com for more information.

Dependent Age Extension Benefit ☐ Yes ☐ No
Submission of a completed Add/Term/Change form is required for dependant enrollment.

E. Certification

By signing this certification of eligibility, I certify under penalty of perjury that I am a resident of New York State and all statements contained in this certification are true to the best of my knowledge. I further certify all individuals to be covered under my policy are ineligible for Medicare.

Signature:_____ Date:_____

Any person who knowingly and with the intent to defraud an insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning an fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

*These amounts may be increased in accordance with NY Department annual increases.

UnitedHealthcare®
Oxford

Dental Enrollment Form

Oxford Health Plans, Inc.

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

Plan Type: ❑ Premium ❑ Enhanced

To Be Completed By Employer (Please Print)

GROUP NAME	GROUP ID NUMBER	EMPLOYEE'S EFFECTIVE DATE OF COVERAGE
		/ /
EMPLOYER SIGNATURE X		

To Be Completed By EMPLOYEE (Please Print)

LAST NAME	FIRST NAME & MI		
STREET ADDRESS	APT. NO.	HOME PHONE	BUSINESS PHONE
CITY / STATE / ZIP	SOCIAL SECURITY NUMBER	❑ MALE ❑ FEMALE	DATE OF BIRTH MO. DAY YEAR
PRIMARY CARE DENTIST NAME*	PROVIDER CODE		

Dependent Information (Please Print)

SPOUSE'S LAST NAME	FIRST NAME	MI	❑ MALE ❑ FEMALE	
PRIMARY CARE DENTIST NAME*	PROVIDER CODE	SOCIAL SECURITY NUMBER	DATE OF BIRTH MO. DAY YEAR	
ELIGIBLE CHILD'S LAST NAME	FIRST NAME	MI	❑ MALE ❑ FEMALE	
PRIMARY CARE DENTIST NAME*	PROVIDER CODE	SOCIAL SECURITY NUMBER	DATE OF BIRTH MO. DAY YEAR	
ELIGIBLE CHILD'S LAST NAME	FIRST NAME	MI	❑ MALE ❑ FEMALE	
PRIMARY CARE DENTIST NAME*	PROVIDER CODE	SOCIAL SECURITY NUMBER	DATE OF BIRTH MO. DAY YEAR	
ELIGIBLE CHILD'S LAST NAME	FIRST NAME	MI	❑ MALE ❑ FEMALE	
PRIMARY CARE DENTIST NAME*	PROVIDER CODE	SOCIAL SECURITY NUMBER	DATE OF BIRTH MO. DAY YEAR	

* You must select a General Practice (GP) Dentist from Oxford's Roster of Participating Dentists for each family member.

Do you or your spouse have any other Group Dental Coverage? ❑ Yes ❑ No If yes, please give:

Name of Group Administrator/Plan ____________________ Policy # ____________________

I understand that my enrollment and benefits are in accordance with those described in the Oxford's Dental Rider. I agree to choose a participating Oxford General Practice Dentist for my primary dental care and to seek any necessary specialty care through Oxford participating Dental Specialists. I authorize any provider or insurer to furnish Oxford with any records concerning me or any member of my family for whom information is required. A photographic copy of this authorization shall be as valid as the original. I agree to submit any disputes with Oxford in accordance with the Oxford Health Plans Contract. I authorize my employer to deduct from my wages the amount required (if any) to cover my contribution for coverage. I certify that I and any of my dependents have no other dental insurance other than listed above. I certify that all the above information is correct.

X

EMPLOYEE SIGNATURE DATE

Oxford Health Insurance, Inc.

New York Health Benefits Waiver of Coverage

Mailing Address: Enrollment Dept. ■ 14 Central Park Drive ■ Hookset, NH 03106 ■ 1-888-201-4216 ■ www.oxfordhealth.com

Group Name: _____

Group Policy Number (if known): _____

Employee Name: _____

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced

Date of Employment: _____

Date of Birth: _____

I am employed by and working at least 20 hours per week for the group shown above. I was given the opportunity to enroll in this plan of group health benefits offered by my employer and I refuse coverage.

Reason for Refusal (please check all appropriate boxes)

❑ I have other coverage from:

- ❑ My spouse's employer
- ❑ Medicare
- ❑ Medicaid
- ❑ Veteran's Administration
- ❑ Union health plan
- ❑ Another carrier's group health plan sponsored by this employer
- ❑ Another source of coverage (please specify): _____

REQUIRED INFORMATION: _____
Name of carrier Policy number

❑ Other reason (please explain): _____

I certify that all information provided in this form is true and complete. By refusing group health benefits, I acknowledge that I and/or my dependents may have to wait until the plan's next anniversary date to be enrolled for group coverage.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed $5,000 dollars and the stated value of the claim for each violation. Any material misrepresentation within this waiver may subject the group to termination.

Signature of Employee Date

Signature of Benefits Administrator Date