UnitedHealthcare®
Oxford

Connecticut Small Group Blue Ribbon Application

Oxford Health Insurance, Inc.

Mailing Address: P.O. Box 7085, Bridgeport, CT 06601-7085 •800-889-7658• *www.oxfordhealth.com*

I. GENERAL INFORMATION

1. Full legal name of company:

2. Address of company:

(Street Address
City, State, Zip Code **Please* -
Do not use a PO Box.)

3. Benefit Administrator/Contact:

a. Name and Title:

b. Address:
(If different from address of company)

c. Phone Number:
Area Code

d. Fax Number
Area Code

e. E-mail Address

4. Person to receive correspondence/billing statements:

a. Name:

b. Title:

c. Address:
(Street Address
City, State, Zip Code)

d. Phone Number:
Area Code

5. Start Date of Business:

6. Name and Address of Parent Company:

a. Name:

b. Address:

7. Full legal name and address of each subsidiary, affiliated company, branch or satellite office whose employees are to be covered:

8. Nature of business:

9. SIC Code filed with the State of CT:

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

Federal I.D. _____ State Tax I.D. _____

11. Is your group subject to:

a. COBRA (20+ lives)? ❒ Yes ❒ No

b. State Continuation (<20 lives)? ❒ Yes ❒ No

12. Did your group employ 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" means 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.

* Please Note: Do not cancel existing coverage until you have received acceptance of this coverage by Underwriting.

* If no previous coverage, initial here _____.

Type of coverage	Name of carrier	Effective date	If terminated, date terminated

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.

a) Defining Eligible Employees:

Active Employees: All active, eligible, full-time employees who work at least _____ hours per week, including business owners and principals (minimum 30 hours/week).

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 (select one Eligibility option and one Termination option).

CLASS I

Definition of Class I _____

_____

i) Eligibility

❑ Date on which the employee completes:

*_____ months of continuous service, or

*_____ days of continuous service.

❑ On the first day of the calendar month coinciding with or next following the date on which the employee completes:

*_____ months of continuous service, or

*_____ days of continuous service.

*** 6 months maximum**

ii) Termination

❑ On the last day of the calendar month in which employee's employment terminates.

❑ Date of termination of employment.

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

CLASS II

Definition of Class II _____

_____

i) Eligibility

❑ Date on which the employee completes:

*_____ months of continuous service, or

*_____ days of continuous service.

❑ On the first day of the calendar month coinciding with or next following the date on which the employee completes:

*_____ months of continuous service, or

*_____ days of continuous service.

*** 6 months maximum**

ii) Termination

❑ On the last day of the calendar month in which employee's employment terminates.

❑ Date of termination of employment.

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

6. Number of Active Employees as of the Effective Date: Total employees _____

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

   How many are part-time or temporary employees? _____

   How many are retired employees? _____

7. Are there any employees or dependents of employees who are covered under COBRA or State Continuation on your current plan? ❒ Yes ❒ No

8. 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? _____

- *If you answered "Yes" to either question 7 or 8 above, please complete the information below.*

Question 7 or 8	Date of Qualifying Event	Name of Employee, Dependent or COBRA Continuant	Reason

9. 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.

10. 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.

11. Dependent Eligibility: Dependents are defined as follows:
    - a legal spouse
    - any child (natural, adopted, placed for adoption, or step child) of the insured or insured's spouse who is under the age of 26 and who:
      - is not married; or
      - is a resident of the state (this does not apply to children under 19 years of age or full-time students)

    Coverage for dependent children will end on the last day of the month following the month in which the child:
    - marries; or
    - becomes covered under a group health plan through the child's own employment; or
    - ceases to be a resident of Connecticut (this does not apply to children under the age of 19 or full-time students)

    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 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.

12. Plan Exclusions and Limitations: Please refer to your Group Certificate for a complete list of exclusions and limitations.

III. BLUE RIBBON PLAN DESIGN

Gated PPO includes:

In-Network:

1. Standard Deductible	$500
2. Coinsurance	10%
3. Inpatient Facility Deductible	$500
4. Skilled Nursing Facility Deductible	$500
5. Emergency Room (Standard Deductible applies)	$500
6. Durable Medical Equipment Deductible (Standard Deductible applies)	$500
7. Prosthesis Deductible (Standard Deductible applies)	$500
8. Pharmacy (includes Contraceptives) (Standard Deductible applies)	$500

Out-of-Network:

1. Standard Deductible	$500
2. Coinsurance	20%
3. Inpatient Facility Deductible	$500
4. Skilled Nursing Facility Deductible	$500
5. Emergency Room (Standard Deductible applies)	$500
6. Durable Medical Equipment Deductible (Standard Deductible applies)	$500
7. Prosthesis Deductible (Standard Deductible applies)	$500
8. Pharmacy (includes Contraceptives)	$500

Maximums and Limitations

1. Pharmacy (includes Contraceptives)	$5 Copay
2. Physical Therapy Limit	30 visits per prescribed course of treatment (In- and Out-of-Network)
3. Dependent age cutoff	19/26
4. Out of Pocket for Covered Services	$1,500 single/ $3,000 family (In- and Out-of-Network)

Medicare Part D 28% Subsidy - for Rx plan design above, do you currently participate or plan to participate with the 28% Government Subsidy for your Medicare eligible retirees?

❒ Yes ❒ No

IV. UNDERWRITING GUIDELINES

The undersigned authorized officer of the Applicant hereby confirms that the Applicant satisfies, and if this Application is accepted by Oxford, will continue to satisfy and remain in compliance with the Underwriting Guidelines set forth in Attachment A, hereto, and any additional underwriting guidelines that Oxford may promulgate and which Applicant is given notice of in conjunction with future renewals. The Applicant hereby acknowledges that if at any time it is not in compliance with such underwriting guidelines or if any census data provided by the Applicant to Oxford, in conjunction with this Application for coverage do not accurately reflect, in the judgment of Oxford, the actual Applicant members covered by Oxford, on the date coverage by Oxford first
commences, then Oxford shall have the right, at any time upon 30 days written notice to the Applicant, to increase the monthly premiums payable by the Applicant in such amount as is determined by Oxford, in its absolute discretion, to reflect the increased risk of such non-compliance or census variance.

_____

Name of Applicant

_____

Signature of Authorized Officer of Applicant | Title of Officer of Applicant | Date

V. 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. 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. In general, our total bonuses are less than 10% of total producer compensation paid. 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.

V. COBRA & EXTENSION OF BENEFITS DATA

1. 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 _____

2. 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. 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 _____

Signature of Authorized Officer of the Applicant

Title of Officer of Applicant

X _____

Witness

X _____

Duly Licensed Resident Agent/Broker