Connecticut Small Group Application – OHP

Oxford Health Plans (CT), Inc.

Mailing Address: 14 Central Park Drive, Hooksett, NH 03106

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. **Plan Administrator/Contact:**
   a. Name and Title:
   b. Address:
   (If different from address of company)
   c. Phone Number: Area Code Ext
   d. Fax Number: Area Code
   e. Email Address:

4. **Name and title of person to receive correspondence/billing statements:**
   a. Name:
   b. Title:
   c. Address:
   (Street Address
   City, State, ZIP Code)
   d. Phone Number: Area Code Ext
   e. Fax Number: Area Code

5. **Start date of business:**

6. **Full legal name and address of parent company:**
   a. Name:
   b. Address:

I. General information (continued)

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

a. Name:

b. Address:

8. Nature of business:

9. SIC Code filed with the State of CT:

10. Type of Organization: ☐ Corporation ☐ Partnership ☐ Proprietorship ☐ LLC ☐ LLP ☐ Other (explain)_____

Did you have any employees other than yourself and your spouse during the preceding calendar year? ☐ Yes ☐ No

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 daysduring the preceding 12 months? ☐ Yes ☐ No

14. Enter the Prior Calendar Year Average Total Number of Employees _____

Under the Health Care Reform law, the number of employees means the average number of employees employed by the company during the preceding calendar year. An employee is typically any person for which the company issues a W-2, regardless of full-time, part-time or seasonal status or whether or not they have medical coverage.

To calculate the annual average, add all the monthly employee totals together, then divide by the number of months you were in business last year (usually 12 months). When calculating the average, consider all months of the previous calendar year regardless of whether you had coverage with us, had coverage with a previous carrier or were in business but did not offer coverage. Use the number of employees at the end of the month as the "monthly value" to calculate the year average. If you are a newly formed business, calculate your prior year average using only those months that you were in business. Use whole numbers only (no decimals, fractions or ranges).

15. Enter the Prior Calendar Year Full Time Equivalent Total Number of Employees _____

For purposes of determining your number of full-time equivalent employee count, the number of employees means the average number of employees employed full-time (at least 30 hours/week in any given month), by the company on business days during the preceding calendar year. In addition to the number of full-time employees noted above, for any month otherwise determined, include for such month the number of full-time employees divided by the aggregate number of hours of service of all employees who are not full-time employees for the month by 120. Employers should exclude employees who were seasonal workers who worked 120 days or fewer in the preceding calendar year.

16. Subject to ERISA? ☐ Yes ☐ No (Most private sector plans are ERISA plans)

If No, please indicate appropriate category:

☐ Church (Additional information needed)
☐ Indian Tribe – Commercial Business
☐ Foreign Government/Foreign Embassy
☐ Federal Government
☐ Non-Federal Government (State, Local or Tribal Gov.)
☐ Non-ERISA Other _____

17. **Does your group sponsor a plan that covers employees of more than one employer?** ☐ Yes ☐ No
If you answered Yes, then indicate which of the following most closely describes your plan:

☐ Professional Employer Organization (PEO)
☐ Multiple Employer Welfare Arrangement (MEWA)
☐ Taft Hartley Union
☐ Governmental
☐ Church
☐ Employer Association

18. **Is your group a Professional Employer Organization (PEO) or Employee Leasing Company (ELC), or other such entity that is a co-employer with your client(s) or client-site employee(s)? ☐ Yes ☐ No**

19. **Do you currently utilize the services of a Professional Employer Organization (PEO) or Employee Leasing Company (ELC), Staff Leasing Company, HR Outsourcing Organization (HRO), or Administrative Services Organization (ASO)?**
☐ Yes ☐ No

20. **Do you have common ownership with any other businesses? ☐ Yes ☐ No**
If you own multiple companies, or a parent-subsidiary relationship exists between your company and another, this may indicate common ownership of businesses.

21. **UnitedHealthcare's Leave of Absence (LOA) Policy; Eligibility for Medical Coverage**

If the employee is on an employer approved leave of absence and the employer continues to pay required medical premiums, the coverage will remain in force for: (1) No longer than 13 consecutive weeks for non-medical leaves (i.e. temporarily laid-off). (2) No longer than 26 consecutive weeks for a medical leave. Coverage may be extended for a longer period of time, if required by local, state or federal rules.

If the employee's medical coverage terminates under this LOA policy, the employee may exercise the rights under any applicable Continuation of Medical Coverage provision or the Conversion of Medical Benefits provision described in the Certificate of Coverage.

Do you continue medical coverage during a leave of absence (not including state continuation or COBRA coverage)?

___ Yes, we continue medical coverage during an approved leave of absence for full time* employees (as defined in section II).

___ No, we do not offer medical coverage during a leave of absence.

The Employer's decision to refuse to offer coverage cannot be based upon health status related factors.

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.

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 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 (20-29 hours if elected by the Group). Also, if the minimum hours are more than the required hours, please enter the hours per week here _____.

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 and 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. Waiting period cannot exceed 90 days. In (i) below, if there is no waiting period, insert "O" 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 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)

6. **Number of Total Employees on the Effective Date:** Full-time employees ___ Part-time employees ___ Retired employees ____
Of the total employees: Were 51% or more active eligible full-time employees working in Connecticut? _____

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 coordinated with Medicare benefits for any employee over the age of 65 who is not actively at work. Health benefits covered by Medicare Part A, Part B and Part D are carved out 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
- any child (natural, adopted, placed for adoption, or stepchild) of the insured or insured's spouse who is under the age of 26

Coverage for dependent children who have reached the limiting age ends on the group's policy anniversary date following the attainment of the limiting age.

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 provided proof of such incapacity and dependency is furnished to Oxford within thirty-one (31) days of the child 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 and plan designs

Please select a plan from section A, B or C

A. Gold Plans

Option	☐ CT G FRDM NG 25/50/1000/100 HMO 21	☐ CT G FRDM NG 25/50/2500/100 HMO 21	☐ CT G FRDM NG 25/50/2500/50 HMO 21
Network	Freedom	Freedom	Freedom
Gatekeeper	N	N	N
Copayment a. PCP b. Specialist	 $25 $50	 $25 $50	 $25 $50
In-Network Deductible (Single)	$1,000	$2,500	$2,500
In-Network Deductible (Family)	$2,000	$5,000	$5,000
In-Network Maximum Out of Pocket (Single)	$7,900	$6,500	$6,000
In-Network Maximum Out of Pocket (Family)	$15,800	$13,000	$12,000
In-Network Coinsurance	100%	100%	50%
Outpatient Facility Freestanding Hospital	 $500 $500	 $350 after ded. $350 after ded.	 50% after ded. 50% after ded.
Inpatient Facility	$750 per day up to $1,500 per admit	$750 per admit after ded.	50% after ded.
Emergency Room	$350 after ded.	$350 after ded.	50% after ded.
Out of Network Deductible (Single)	N/A	N/A	N/A
Out of Network Deductible (Family)	N/A	N/A	N/A
Out of Network Maximum Out of Pocket (Single)	N/A	N/A	N/A
Out of Network Maximum Out of Pocket (Family)	N/A	N/A	N/A
Out of Network Coinsurance	N/A	N/A	N/A
Prescription Drug	Tier 1 - $5 Tier 2 - $60 Tier 3 - 50% up to $500 maximum Tier 4 - 50% up to $750 maximum Mail order = 2.5 x copayment	Tier 1 - $5 Tier 2 - $60 Tier 3 - 50% up to $500 maximum Tier 4 - 50% up to $750 maximum Mail order = 2.5 x copayment	Tier 1 - $5 Tier 2 - $60 Tier 3 - 50% up to $500 maximum Tier 4 - 50% up to $750 maximum Mail order = 2.5 x copayment

Deductibles and out-of-pocket accumulation periods are on a ☐ calendar year ☐ contract year basis.

Additional Benefit Options:

☐ **Domestic Partner**

Contraceptives ☐ Yes (Standard) ☐ No (Qualified State-Exempt Groups Only)

III. Product and plan designs (continued)

B. Gold Plans (continued)

Option	☐ CT G LBTY GT 25/70/3000/100 HMO 21	☐ CT G LBTY GT 25/70/3000/90 HMO 21	☐ CT G LBTY GT 25/70/3500/100 HMO 21	☐ CT G LBTY GT 25/70/2500/80 HMO 21
Network	Liberty	Liberty	Liberty	Liberty
Gatekeeper	Y	Y	Y	Y
Copayment				
a. PCP	100%/$25	100%/$25	100%/$25	100%/$25
b. Specialist	$45/$70	$45/$70	$45/$70	$45/$70
In-Network Deductible (Single)	$3,000	$3,000	$3,500	$2,500
In-Network Deductible (Family)	$6,000	$6,000	$7,000	$5,000
In-Network Maximum Out of Pocket (Single)	$6,500	$7,000	$7,500	$7,500
In-Network Maximum Out of Pocket (Family)	$13,000	$14,000	$15,000	$15,000
In-Network Coinsurance	100%	90%	100%	80%
Outpatient Facility				
Freestanding	100% after ded.	90% after ded.	100% after ded.	80% after ded.
Hospital	100% after ded.	90% after ded.	100% after ded.	80% after ded.
Inpatient Facility	100% after ded.	90% after ded.	100% after ded	80% after ded.
Emergency Room	$300 after ded.	90% after ded.	$300 after ded.	50% after ded.
Out of Network Deductible (Single)	N/A	N/A	N/A	N/A
Out of Network Deductible (Family)	N/A	N/A	N/A	N/A
Out of Network Maximum Out of Pocket (Single)	N/A	N/A	N/A	N/A
Out of Network Maximum Out of Pocket (Family)	N/A	N/A	N/A	N/A
Out of Network Coinsurance	N/A	N/A	N/A	N/A
Prescription Drug	Tier 1 - $5 Tier 2 - $60 Tier 3 - 50% up to $500 maximum* Tier 4 - 50% up to $750 maximum* Mail order = 2.5 x copayment *Rx deductible	Tier 1 - $5 Tier 2 - $60 Tier 3 - 50% up to $500 maximum* Tier 4 - 50% up to $750 maximum* Mail order = 2.5 x copayment *Rx deductible	Tier 1 - $5 Tier 2 - $60 Tier 3 - 50% up to $500 maximum* Tier 4 - 50% up to $750 maximum* Mail order = 2.5 x copayment *Rx deductible	Tier 1 - $5 Tier 2 - $60 Tier 3 - 50% up to $500 maximum* Tier 4 - 50% up to $750 maximum* Mail order = 2.5 x copayment *Rx deductible

Deductibles and out-of-pocket accumulation periods are on a ☐ calendar year ☐ contract year basis.

Additional Benefit Options:

☐ **Domestic Partner**

Contraceptives ☐ Yes (Standard) ☐ No (Qualified State-Exempt Groups Only)

B. Silver Plans

Option	☐ CT S FRDM NG 30/60/3000/100 HMO HSA 21	☐ CT S FRDM NG 35/75/6000/100 HMO 21	☐ CT S FRDM NG 30/60/5000/50 HMO 21	☐ CT S FRDM NG 3000/80 HMO HSAM 21
Network	Freedom	Freedom	Freedom	Freedom
Gatekeeper	N	N	N	N
Copayment				
a. PCP	$30 after ded.	$35	$30	80% after ded.
b. Specialist	$60 after ded.	$75	$60	80% after ded.
In-Network Deductible (Single)	$3,000	$6,000	$5,000	$3,000
In-Network Deductible (Family)	$6,000	$12,000	$10,000	$6,000
In-Network Maximum Out of Pocket (Single)	$6,950	$8,500	$8,300	$6,950
In-Network Maximum Out of Pocket (Family)	$13,900	$17,000	$16,600	$13,900
In-Network Coinsurance	100%	100%	50%	80%
Outpatient Facility				
Freestanding	100% after ded.	$500 after ded.	50% after ded.	80% after ded.
Hospital	100% after ded.	$500 after ded.	50% after ded.	80% after ded.
Inpatient Facility	100% after ded.	$750 per day up to $2,250 after ded.	50% after ded.	80% after ded.
Emergency Room	$350 after ded.	$350 after ded	50% after ded.	80% after ded.
Out of Network Deductible (Single)	N/A	N/A	N/A	N/A
Out of Network Deductible (Family)	N/A	N/A	N/A	N/A
Out of Network Maximum Out of Pocket (Single)	N/A	N/A	N/A	N/A
Out of Network Maximum Out of Pocket (Family)	N/A	N/A	N/A	N/A
Out of Network Coinsurance	N/A	N/A	N/A	N/A
Prescription Drug	Tier 1 - $10 Tier 2 - $60 Tier 3 - 50% up to $500 maximum Tier 4 - 50% up to $750 maximum Mail order = 2.5 x copayment	Tier 1 - $10 Tier 2 - $60 Tier 3 - 50% up to $500 maximum Tier 4 - 50% up to $750 maximum Mail order = 2.5 x copayment	Tier 1 - $5 Tier 2 - $60 Tier 3 - 50% up to $500 maximum Tier 4 - 50% up to $750 maximum Mail order = 2.5 x copayment	Tier 1 - $10 Tier 2 - $60 Tier 3 - 50% up to $500 maximum Tier 4 - 50% up to $750 maximum Mail order = 2.5 x copayment *Medical Ded.

Deductibles and out-of-pocket accumulation periods are on a ☐ calendar year ☐ contract year basis.

Additional Benefit Options:

☐ **Domestic Partner**

Contraceptives ☐ Yes (Standard) ☐ No (Qualified State-Exempt Groups Only)

III. Product and plan designs (continued)

Option	☐ CT S LBTY GT 3000/80 HMO HSAM 21	☐ CT S LBTY GT 4000/100 HMO HSAM 21	☐ CT S LBTY GT 30/80/5000/100 HMO 21	☐ CT S LBTY GT 35/80/7500/100 HMO 21
Network	Liberty	Liberty	Liberty	Liberty
Gatekeeper	Y	Y	Y	Y
Copayment				
a. PCP	80% after ded.	100% after ded.	100%/$30	100%/$35
b. Specialist	80% after ded.	100% after ded.	$50/$80 after ded.	$60/$80
In-Network Deductible (Single)	$3,000	$4,000	$5,000	$7,500
In-Network Deductible (Family)	$6,000	$8,000	$10,000	$15,000
In-Network Maximum Out of Pocket (Single)	$6,950	$6,950	$8,350	$8,500
In-Network Maximum Out of Pocket (Family)	$13,900	$13,900	$16,700	$17,000
In-Network Coinsurance	80%	100%	100%	100%
Outpatient Facility				
Freestanding	80% after ded.	100% after ded.	$500 after ded.	100% after ded.
Hospital	80% after ded.	100% after ded.	$500 after ded.	100% after ded.
Inpatient Facility	80% after ded.	100% after ded.	$750 per day up to $3,000 after ded.	100% after ded.
Emergency Room	80% after ded.	100% after ded.	$300 after ded.	100% after ded.
Out of Network Deductible (Single)	N/A	N/A	N/A	N/A
Out of Network Deductible (Family)	N/A	N/A	N/A	N/A
Out of Network Maximum Out of Pocket (Single)	N/A	N/A	N/A	N/A
Out of Network Maximum Out of Pocket (Family)	N/A	N/A	N/A	N/A
Out of Network Coinsurance	N/A	N/A	N/A	N/A
Prescription Drug	Tier 1 - $5 Tier 2 - $60 Tier 3 - 50% up to $500 maximum Tier 4 - 50% up to $750 maximum Mail order = 2.5 x copayment (Medical Ded.)	Tier 1 - $5 Tier 2 - $60 Tier 3 - 50% up to $500 maximum Tier 4 - 50% up to $750 maximum Mail order = 2.5 x copayment (Medical Ded.)	Tier 1 - $5 Tier 2 - $60 Tier 3 - 50% up to $500 maximum* Tier 4 - 50% up to $750 maximum* Mail order = 2.5 x copayment *Rx deductible	Tier 1 - $5 Tier 2 - $60 Tier 3 - 50% up to $500 maximum* Tier 4 - 50% up to $750 maximum* Mail order = 2.5 x copayment *Rx deductible

Deductibles and out-of-pocket accumulation periods are on a ☐ calendar year ☐ contract year basis.

Additional Benefit Options:

☐ **Domestic Partner**

Contraceptives ☐ Yes (Standard) ☐ No (Qualified State-Exempt Groups Only)

B. Silver Plans (continued)

Option	☐ CT S LBTY GT 30/80/2500/100 HMO HSA 21	☐ CT S LBTY GT 30/80/5500/80 HMO 21
Network	Liberty	Liberty
Gatekeeper	Y	Y
Copayment		
a. PCP	100%/$30 after ded.	100%/$30
b. Specialist	$50/$80 after ded.	$50/$80
In-Network Deductible (Single)	$2,500	$5,500
In-Network Deductible (Family)	$5,000	$11,000
In-Network Maximum Out of Pocket (Single)	$6,950	$8,500
In-Network Maximum Out of Pocket (Family)	$13,900	$17,000
In-Network Coinsurance	100%	80%
Outpatient Facility		
Freestanding	$500 after ded.	80% after ded.
Hospital	$500 after ded.	80% after ded.
Inpatient Facility	$750 per admit after ded.	80% after ded.
Emergency Room	$300 after ded.	50% after ded.
Out of Network Deductible (Single)	N/A	N/A
Out of Network Deductible (Family)	N/A	N/A
Out of Network Maximum Out of Pocket (Single)	N/A	N/A
Out of Network Maximum Out of Pocket (Family)	N/A	N/A
Out of Network Coinsurance	N/A	N/A
Prescription Drug	Tier 1 - $5 Tier 2 - $60 Tier 3 - 50% up to $500 maximum Tier 4 - 50% up to $750 maximum Mail order = 2.5 x copayment (Medical Ded)	Tier 1 - $5 Tier 2 - $60 Tier 3 - 50% up to $500 maximum* Tier 4 - 50% up to $750 maximum* Mail order = 2.5 x copayment *Rx deductible

Deductibles and out-of-pocket accumulation periods are on a ☐ calendar year ☐ contract year basis.

Additional Benefit Options:

☐ **Domestic Partner**

Contraceptives ☐ Yes (Standard) ☐ No (Qualified State-Exempt Groups Only)

B. Bronze Plans

Option	☐ CT B FRDM NG 40/60/6250/100 HMO HSA 21	☐ CT B LBTY GT 6250/80 HMO HSAM 21
Network	Freedom	Liberty
Gatekeeper	N	Y
Copayment		
a. PCP	$40 after ded.	80% after ded.
b. Specialist	$60 after ded.	80% after ded.
In-Network Deductible (Single)	$6,250	$6,250
In-Network Deductible (Family)	$12,500	$12,500
In-Network Maximum Out of Pocket (Single)	$6,950	$6,950
In-Network Maximum Out of Pocket (Family)	$13,900	$13,900
In-Network Coinsurance	100%	80%
Outpatient Facility		
Freestanding	$500 after ded.	80% after ded.
Hospital	$500 after ded.	80% after ded.
Inpatient Facility	$700 per admit after ded.	80% after ded.
Emergency Room	$350 after ded.	80% after ded.
Out of Network Deductible (Single)	N/A	N/A
Out of Network Deductible (Family)	N/A	N/A
Out of Network Maximum Out of Pocket (Single)	N/A	N/A
Out of Network Maximum Out of Pocket (Family)	N/A	N/A
Out of Network Coinsurance	N/A	N/A
Prescription Drug	Tier 1 - $10 Tier 2 - $60 Tier 3 - 50% up to $500 maximum Tier 4 - 50% up to $750 maximum Mail order = 2.5 x copayment	Tier 1 - $5 Tier 2 - $60 Tier 3 - 50% up to $500 maximum Tier 4 - 50% up to $750 maximum Mail order = 2.5 x copayment (Medical Ded.)

Deductibles and out-of-pocket accumulation periods are on a ☐ calendar year ☐ contract year basis.

Additional Benefit Options:

☐ **Domestic Partner**

Contraceptives ☐ Yes (Standard) ☐ No (Qualified State-Exempt Groups Only)

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. 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. 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 visit our website. For specific information about the compensation payable with respect to your particular policy, please contact your producer.

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. 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.

I understand that the Certificate of Coverage or Summary Plan Description, and other documents, notices and communications regarding the coverage indicated on this application may be transmitted electronically to me and to the Applicant's employees. This consent remains in effect until it is withdrawn. The Applicant may withdraw their consent at any time or request a document in a paper or non-electronic form.

Please note, that to the extent permitted by applicable State law, an employee's or employer's failure to pay any past-due premium amounts owed for coverage to Oxford or any of its affiliates to whom you are applying for coverage, or any other health insurance company within this health insurer's control group to whom you owe premium, within the past 12 months preceding the requested effective date of any new coverage, will be assigned to the employee's or employer's initial premium payment to effectuate new coverage.

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 | Duly Licensed and Appointed Producer*

Please note: If you are not currently appointed by Oxford in Connecticut, you must contact Oxford's Commissions Department at 1-888-666-6844 in advance of executing this application.