OBM Group Enrollment Checklist

We've created this checklist to make doing business with OBM convenient. All forms listed below are available on *www.oxfordbenefitmanagement.com*. All fields on the following group questionnaire are required, unless otherwise noted.

TO ENROLL A NEW GROUP INTO AN OBM PLAN, THE FOLLOWING GUIDELINES MUST BE MET:

- Effective dates of coverage can only be the 1st of each month.
- The employer must contribute at least 50% towards the employee's premium for Contributory plans and no more than 49% for the Voluntary plan.
- Groups enrolling in Contributory plans must have at least 75% of the active eligible employees enrolled, excluding those waived with spousal coverage.
- Groups enrolling in the voluntary plan must have at least 2 people enrolling to be eligible for coverage.

TO ENROLL A NEW GROUP INTO A PLAN, THE FOLLOWING ITEMS MUST BE SUBMITTED:

- A completed Group Enrollment Checklist.
- A binder check equal to one month's premium made payable to Oxford Benefit Management.
- A rate sheet based on final enrollment census information and current effective date.
- A Wage and Tax Statement
- A recent copy of the group's current dental insurance carrier's Summary of Benefits, as well as a prior carrier bill (only needed if the group had prior dental coverage through another carrier).
- Member enrollment forms, completed and signed for all members enrolling into the plan.

PARTICIPATION

Total number of employees on payroll: _____

Total number of full-time eligible employees: _____

Total number of enrolling employees:

Employee Only: _____

Employee+Spouse: _____

Employee+Child: _____

Employee+Family: _____

Total number of waivers: _____

Note: Participation level for contributory plans must be at least 75% of eligible employees excluding spousal waivers.

Full Legal Group Name: _____

Requested Effective Date: _____

Primary Contact: _____

Group Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

E-mail: _____

Billing Address: (if different from above)

_____

City: _____ State: _____ Zip Code: _____

Nature of Business/SIC Code: _____

Business Type:

□ Corporation □ Partnership □ Proprietorship □ Other

Tax ID: _____ Subject to ERISA? □ Yes □ No

Does your company have UnitedHealthcare medical coverage?

□ Yes □ No

If yes, group ID # _____

Did your company have prior dental coverage?

□ Yes □ No

If yes, dates of coverage: _____ Carrier: _____

Multi Site: □ Yes □ No Number of Locations: _____

Locations: _____

Number of COBRA participants in total group: _____

Number of retirees in total group: _____

Employer Contribution

_____%

Note: Employer Contribution must equal 50% of the employee's premium for Contributory plans and must not exceed 49% for the Voluntary plan.

SALES REPRESENTATIVE INFORMATION

Sales Representative Name:

_____

E-Mail:

_____

See Reverse Side

OBM Group Enrollment Checklist

PLEASE SELECT ONE PLAN OPTION:

□ OBM **Basic** Specialty Option

Optional Term Life Insurance □ $10,000 □ $25,000

□ OBM **Preferred** Specialty Option

Orthodontia: □ Yes □ No

$1500 Maximum: □ Yes □ No

Waive Waiting periods*: □ Yes □ No

Optional Term Life Insurance □ $10,000 □ $25,000

□ OBM **Voluntary** Specialty Option

Orthodontia: □ Yes □ No

$1500 Maximum: □ Yes □ No

□ OBM **Elite** Specialty Option

Orthodontia: □ Yes □ No

$1500 Maximum: □ Yes □ No

Waive Waiting periods*: □ Yes □ No

Optional Term Life Insurance □ $10,000 □ $25,000

□ OBM **Incentive** Specialty Option

Orthodontia: □ Yes □ No

$1500 Maximum: □ Yes □ No

Waive Waiting periods*: □ Yes □ No

Optional Term Life Insurance □ $10,000 □ $25,000

□ OBM **Premier** Specialty Option

Orthodontia: □ Yes □ No

$1500 Maximum: □ Yes □ No

Waive Waiting periods*: □ Yes □ No

Optional Term Life Insurance □ $10,000 □ $25,000

Please Note: Oxford Benefit Management, Inc., acts as the distribution company for products by third-party vendors, including UnitedHealthcare Dental, UnitedHealthcare Vision®, OptumHealth, UnitedHealth Allies Inc. and Unimerica Workplace Benefits (Unimerica). The UnitedHealthcare Dental® Plans and UnitedHealthcare Vision®,Inc. products are either underwritten or provided by: UnitedHealthCare Insurance Company, Harford, Connecticut; United HealthCare Insurance Company of New York, Hauppauge, New York; or UnitedHealthCare Services, Inc. The Unimerica products are underwritten by Unimerica Insurance Company and United HealthCare Insurance Company. In New York, products are underwritten by Unimerica Life Insurance Company of New York.
The UnitedHealth Allies℠ Discount Program offers discounts is administered by HealthAllies, Inc., a discount medical plan organization located at 505 N. Brand Blvd., Suited 850, Glendale, CA, 91203, 1-800-860-8773. UnitedHelaht Allies is NOT insurance. UnitedHealth Allies provides discounts at certain health care providers for medical services. UnitedHealth Allies does not make payments directly to the providers of medical services. The program member is obligated to pay for all health care services but will receive a discount from those health care providers who have contracted with the discount plan organization.
OBM does not underwrite or administer these products and bears no risk on any product offered. All information within this document is subject to change.

BROKER INFORMATION

Brokerage: _____

Broker Name: _____

Broker#: _____

FTIN/SS#: _____

License#: _____

Mailing Address: _____

_____

City: _____ State: _____ Zip Code: _____

Phone: _____

Fax: _____

E-mail: _____

Broker Signature: _____ Date: _____

Commission Percentage: _____

Commission Checks Payable To:

_____

GENERAL AGENT INFORMATION

GA Name: _____

GA#: _____

FTIN/SS#: _____

License#: _____

Mailing Address: _____

_____

City: _____ State: _____ Zip Code: _____

Phone: _____

Fax: _____

E-mail: _____

GA Signature: _____ Date: _____

Commission Checks Payable To: _____

SUBMISSIONS SHOULD BE MAILED TO:

Oxford Benefit Management
12 Christopher Way, Suite 104
Eatontown, NJ 07724

OR EMAILED TO:

OBM@ancillary-benefits.com

UnitedHealthcare®