



**Liberty Plan<sup>SM</sup> Direct**  
**Oxford Exclusive Plan<sup>SM</sup> Metro**  
**Oxford<sup>®</sup> HSA Direct<sup>SM</sup>**  
**Oxford<sup>®</sup> HSA Exclusive<sup>SM</sup>**

# New York Sole Proprietor Application

Oxford Health Insurance Inc.  
 Mailing Address: HealthPass, 7120 Lake Ellenor Drive, Orlando, FL 32809; Fax: (888) 354-7277

## I. GENERAL INFORMATION

1. **Full Legal Name of Group:**

2. **Primary Address of Group:**   
(Street Address)  
  
City, State, ZIP Code  
\*No P.O. Box

3. **Plan Administrator/Contact:**

a. Name

b. Title

c. Address   
(If different from primary)  
 City, State, ZIP Code

d. Phone Number    Ext.

e. Fax Number

f. E-mail Address

g. Add'l Contact & Number

4. **Name and title of person to receive billing statements:**

a. Name

b. Title

c. Address   
(If different from primary)  
 City, State, ZIP Code

d. Phone Number    Ext.

e. Fax Number

5. **Nature of Business:**

6. **SIC Code:**

7. **Tax Identification Number:**

## II. ADMINISTRATIVE INFORMATION

The term "coverage" means the benefits provided by Oxford, pursuant to the group Certificate of Coverage.

1. **Effective date:** We request that this coverage be effective: \_\_\_\_\_  
(Month / Day 1st / Year)
2. **Age of Business:** Please indicate if your business has been in operation:  Less than 12 months  More than 12 months
3. **Other group health or HMO coverage:** Indicate below other group health coverage which is still in force or which terminated within the past three years.

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

4. **Integration with Medicare Benefits:** Health benefits covered by Medicare Part A and B are carved out for retired employees aged 65 and over and their dependents aged 65 and over if the group offers retiree coverage.

## III. PRODUCT AND PLAN DESIGNS

### A. Oxford Sole Proprietor Plan

**Instructions:** Please select a plan option and check off any variable items as provided below.

Benefit Package	Liberty Network		Freedom Network	
	Plan 1 <input type="checkbox"/>	Plan 2 <input type="checkbox"/>	Plan 3 <input type="checkbox"/>	Plan 4 <input type="checkbox"/>
Product	Direct	EPO	Direct HSA	EPO HSA
PCP Copayment	30/50	25/50	N/A	N/A
In-Network Coinsurance %	80%	90%	90%	100%
Out-of-Network Coinsurance %	60%	N/A	70%	N/A
In-Network Single Deductible	\$2,000	\$2,000	\$2,850	\$2,000
Out-of-Network Single Deductible	\$2,000	N/A	\$2,850	N/A
Out-of-Network Reimbursement	140% of Medicare Rate <sup>1</sup>	N/A	140% of Medicare Rate <sup>1</sup>	N/A
Family Multiplier	2.5x	2.5x	2x	2x
Emergency Room Copayment	\$200	\$200	Deductible and Coinsurance	
Inpatient Facility	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	
Outpatient Surgical	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	
Prescription Benefit	15/50% with \$100 Deductible		15/50% with \$2,850 Ded	15/50% with \$2,000 Ded
Domestic Partner	Same and Opposite		Same and Opposite	

Deductibles and out-of-pocket accumulations are on a  calendar year basis  contract year basis (Plans 1-4 only).

### B. Other Riders

- Coverage for Biologically Based Mental Illness and Children with Serious Emotional Disturbances \_\_\_\_\_
- Mandated Offering - Dependent Age Extension to 29

<sup>1</sup> When a Medicare rate is not available, reimbursement is based upon certain gap methodology, including a gap methodology using relative value data from Ingenix, Inc. We and Ingenix are related companies through common ownership by UnitedHealth Group. When a gap methodology is not available, reimbursement is based upon 50% of the provider's billed charge.

## IV. RATE INFORMATION

**Monthly Rates:** All new groups are subject to the four-tier rate structure indicated below. Rates must be included in the spaces below for application processing. Please note: All four categories must be completed.

Single	Couple	Parent/Children	Family
\$	\$	\$	\$

## 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. 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](http://www.oxfordhealth.com). For specific information about the compensation payable with respect to your particular policy, please contact your producer.

## VI. CONSENT

### AUTHORIZATION FOR BROKER TO ACT AS BENEFITS ADMINISTRATOR

The undersigned hereby requests Oxford accept the Broker or General Agent named above as an authorized Benefits Administrator for purposes of processing any enrollment transactions for my company's health plan policy (including, but not limited to, Member enrollments, Member terminations, Member address changes, group contact changes, group address changes, plan renewal changes, and group contract terminations).

This authorization shall be effective immediately and shall (check one only):

\_\_\_\_\_ Remain in place until it is expressly revoked by me in writing.

\_\_\_\_\_ Remain in place until \_\_\_\_\_  
(Month / Day 1st / Year)

Further, I agree that my company will be bound by the actions performed by the herein-named Broker or General Agent pursuant to this Consent Form. Additionally, I agree that this Consent Form does not authorize anyone to receive individually identifiable health information about any Oxford Member. I acknowledge that I must notify Oxford in writing to void this agreement in the event of a change in my company's Broker of Record.

VII. COBRA & EXTENSION OF BENEFITS DATA

- 1. Do you have any individuals currently on COBRA continuation? [ ] Yes [ ] No
If yes, identify the number of individuals \_\_\_\_\_.
2. Are there any dependents of employees who are currently disabled or in the hospital? [ ] Yes [ ] No
3. What is the length of the prior carrier's extension of benefits period for disabled employees or dependents? \_\_\_\_\_

VIII. 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 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. Further, I hereby certify on behalf of the Applicant that the Applicant has not had a group health policy terminated within the past 12 months due to failure to pay premiums.

Dated at: \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_\_.

Full legal name of firm: \_\_\_\_\_

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.

Oxford Health Insurance, Inc.

X

Signature of Authorized Officer of the Company

Title

Witness

Duly Licensed Resident Agent/Broker