United Healthcare Oxford

New Jersey Application for a Small Employer Health Benefits Policy – OHP

Oxford Health Plans (NJ), Inc. (OHP)

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

Please print or type

Policy Number (OHP Use Only): _____

☐ **New Policy** ☐ **Change in Policy**

Requested Effective Date: _____

* Note: The effective date will be on or after the date Oxford approves the application.

I. Policyholder information

1. **Policyholder (**Full legal name of company):

2. **Tax identification number:**

3. **Main address:**
   Street
   City State ZIP Code

   Mailing address:
   Street
   City State ZIP Code

   Telephone & Facsimile: Fax

   Email Address: _____

   Contract information should be provided ☐ **electronically or** ☐ **hard copy. Check one.**

4. **Name of correspondent:**

5. **Type of organization:** ☐ Corporation ☐ Partnership ☐ Proprietorship ☐ Other (explain) _____

6. **Nature of business (specify):** _____ **SIC Code:** _____

7. **Number of full-time employees in your company:** _____
   Refer to the New Jersey Small Employer Certification for the definition of a full-time employee.

8. **Number of full-time employees to be insured:** _____

9. **Class or classes to be excluded:** _____

10. **Insurance requested for:** ☐ Employees Only ☐ Employees and Dependents excluding Spouse
    ☐ Employees and Dependents including Spouse
    Should the plan provide coverage for domestic partners as permitted by P.L. 2003, c.246 ☐ Yes ☐ No
    If yes, should the plan provide coverage for children of a covered domestic partner? ☐ Yes ☐ No

11. **Is the employer subject to the requirements of COBRA?** ☐ Yes ☐ No

12. **Is the employer subject to the requirements of Medicare as Secondary Payer rules for eligibility due to age?**
    ☐ Yes ☐ No
    Due to disability? ☐ Yes ☐ No

I. Policyholder information (continued)

13. Orientation Period: ☐ Yes ☐ No

14. Waiting period before employees become insured (may not exceed 90 days):

Present employees _____ New or rehired employees _____

15. Period for Annual Employee Open Enrollment Period: _____

16. What percentage of the premium will the employer pay? _____

17. Deposit $ _____ **Premium Paid:** ☐ Monthly ☐ Quarterly

Premium will be due as of the effective date. The premium for the first month of coverage must be attached.

Affiliates, subsidiaries or branches (must be included for purposes of participation)

Legal name and location	Number of eligible employees in this company	Number of eligible employees to be insured

II. Specifications for coverage

Silver Plan

Option	☐ NJ S LBTY NG 15/60/2500/90 HMO PA 21
Network	Liberty
Gated/Non-Gated	N
Copayment a. PCP b. Specialist	 $15 $60 after ded
In-Network Deductible (Single) In-Network Deductible (Family)	$2,500 $5,000
In-Network Maximum Out of Pocket (Single) In-Network Maximum Out of Pocket (Family)	$8,550 $17,100
In-Network Coinsurance	10%
Outpatient Facility Freestanding Hospital	 50% after ded 50% after ded
Inpatient Facility	$250 per day after ded up to $1,250
Emergency Room	$100 then 50% after ded
Prescription Drug	Tier 1 - $10 Tier 2 - $50* Tier 3 - 50%* ($150 maximum coinsurance) Mail order = 2x copayment *After medical 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)

III. All questions must be answered

1. Is there any Group Health Plan:
   Now in force and to be continued? ☐ Yes ☐ No
   Currently being applied for? ☐ Yes ☐ No

   If "yes," identify the name of the Group Health Plan, give a description of the plan(s) and the name of insurance carrier(s):

   _____

2. Name of present or prior group carrier: _____

   Effective date of prior coverage:_____ Cancellation/termination date:_____

   Is the coverage applied for in this application replacing other group insurance? ☐ Yes ☐ No

   If "yes," give reason: _____

   Plan being replaced: _____

3. Are extended benefits provided in case of termination of health benefits? ☐ Yes ☐ No

4. To the best of your knowledge are there any current or former employees or their eligible dependents whose health insurance is being continued? ☐ Yes ☐ No

   Please provide the following information for each current/former employee or dependent on health continuations.

Name of Employee/ Dependent	Date of Birth	Type of Continuation State/ Federal/Extended Benefits	Reason for Termination Disability/Other	Continuation Dates Start	End

   If additional space is needed, attach a separate sheet, signed and dated.

5. To the best of your knowledge:
   A. Are any employees or dependents presently incapacitated? ☐ Yes ☐ No
   B. Are any dependent children incapable of self-support due to a physical or mental disability? ☐ Yes ☐ No

   Additional space to explain if Items 1, 2 or 3 were answered "yes." Refer to the question number, and give details including names, where appropriate.

   _____

   _____

   _____

6. Does the employer participate in an arrangement with a Professional Employer Organization? ☐ Yes ☐ No

   (Refer to Advisory Bulletin 00-SEH-02 if you need information concerning what constitutes a Professional Employer Organization.)

IV. Agent/producer information

Broker _____ _____
Name Code Address

Broker _____ _____
Name Code Address

V. Signature

It is understood that, except as provided under applicable regulations, no individual shall become insured while not actively at work on a full-time basis, and only full-time employees are eligible. (Refer to the definition on the New Jersey Employer Certification.) It is further understood that no agent has power on behalf of Oxford to make or modify any request or application for insurance or to bind Oxford by making any promise or representation or by giving or receiving any information.

It is further understood that no insurance will be effective unless and until the application is accepted in writing by Oxford. Final rates will be based on enrollment data as of the Policy effective date. No contract of insurance is to be implied in any way on the basis of the completion and/or submission of this application.

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:_____on_____

_____ _____

Print name of Officer, Partner or Proprietor

Signature of Officer, Partner or Proprietor

_____

Witness to Signature

Note: If there are any modifications to the statements and answers given in this application (i.e., crossed out, whited-out, erased information), the applicant must attest to the modifications by giving a complete signature in the margin near the modification.