# Oxford Benefit Management (OBM) Group Enrollment Checklist

We've created this checklist to make doing business with OBM convenient. All forms listed below are available on **www.uhc.com/obm**. 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 percent towards the employee's premium for Contributory plans and no more than 49 percent for the Voluntary plan.
- Groups enrolling in Contributory plans must have at least 75 percent of the active eligible employees enrolled, excluding those waived with spousal coverage.
- Groups enrolling in the voluntary plan must have at least two people enrolling to be eligible for coverage.

## To enroll a new group into a plan, the following items must be submitted:

- A completed OBM 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 percent of eligible employees excluding spousal waivers.

Full Legal Group Name: _____

Requested Effective Date: _____

Primary Contact: _____

Group Address: _____

City: _____

State: _____ ZIP Code: _____

Phone: _____ Fax: _____

Email: _____

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, 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 percent of the employee's premium for Contributory plans and must not exceed 49 percent for the Voluntary plan.

## Sales Representative Information

Sales Representative Name:

_____

Email: _____

**See Reverse Side**

UnitedHealthcare® Oxford

## Please select one plan option:

☐ OBM **Basic** Specialty Option

☐ OBM **Preferred** Specialty Option

| | | |
|---|---|---|
| Orthodontia: | ☐ Yes | ☐ No |
| $1,500 Maximum: | ☐ Yes | ☐ No |
| Waive Waiting Periods*: | ☐ Yes | ☐ No |

☐ OBM **Voluntary** Specialty Option

Note: Does not include $25,000 Employee Basic Life coverage.

| | | |
|---|---|---|
| Orthodontia: | ☐ Yes | ☐ No |
| $1,500 Maximum: | ☐ Yes | ☐ No |

☐ OBM **Elite** Specialty Option

| | | |
|---|---|---|
| Orthodontia: | ☐ Yes | ☐ No |
| $1,500 Maximum: | ☐ Yes | ☐ No |
| Waive Waiting Periods*: | ☐ Yes | ☐ No |

☐ OBM **Incentive** Specialty Option

| | | |
|---|---|---|
| Orthodontia: | ☐ Yes | ☐ No |
| $1,500 Maximum: | ☐ Yes | ☐ No |
| Waive Waiting Periods*: | ☐ Yes | ☐ No |

☐ OBM **Premier** Specialty Option

| | | |
|---|---|---|
| Orthodontia: | ☐ Yes | ☐ No |
| $1,500 Maximum: | ☐ Yes | ☐ No |
| Waive Waiting Periods*: | ☐ Yes | ☐ No |

## Submissions should be mailed to:

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

## Or emailed to:

**OBM@ancillary-benefits.com**

## Broker Information

Brokerage: _____

Broker Name: _____

Broker #: _____

FTIN/SS #: _____

License #: _____

Mailing Address: _____

_____

City: _____

State: _____ ZIP Code: _____

Phone: _____

Fax: _____

Email: _____

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: _____

Email: _____

GA Signature: _____ Date: _____

Commission Checks Payable to: _____

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UnitedHealthcare vision coverage provided by or through UnitedHealthcare Insurance Company, located in Hartford, Connecticut, UnitedHealthcare Insurance Company of New York, located in Islandia, New York, or their affiliates. Administrative services provided by Spectera, Inc., United HealthCare Services, Inc. or their affiliates. The policies may include exclusions, limitations, reductions of benefits, and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, call or write your insurance agent or the company.

UnitedHealthcare Life and Disability products are provided by UnitedHealthcare Insurance Company and in New York by Unimerica Life Insurance Company of New York. Life products are provided on policy forms LASD-POL (05/03) et al. and Disability products are provided on policy forms UHCLD-POL 2/2008 et al. In New York, the Life Insurance product is provided on Form LASD-POL-LIFE NY (05/03) and the Disability product on Form LASD-POL-ADD/DIS NY (05/03). UnitedHealthcare Insurance Company is located in Hartford, CT and Unimerica Life Insurance Company of New York in New York, NY. Participation requirements for Life and Disability Insurance may be different than those stated. These policies may include exclusions, limitations, reductions of benefits, and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, call or write your insurance agent or the company.

Disclosure: The health discount program is administered by HealthAllies®, Inc., a discount medical plan organization. The health discount program is NOT insurance. The discount program provides discounts at certain health care providers for medical services. The discount program does not make payments directly to the providers of medical services. The discount 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. HealthAllies, Inc. is located at P.O. Box 10340, Glendale, CA 91209, 1-800-860-8773, www.unitedhealthallies.com.

The health discount program is offered to existing members of certain products underwritten or provided by UnitedHealthcare Insurance Company or its affiliates to provide specific discounts and to encourage participation in wellness programs. Health care professional availability for certain services may be dependent on licensure, scope of practice restrictions or other requirements in the state. UnitedHealthcare does not endorse or guarantee health products/services available through the discount program. This program may not be available in all states or for all groups. Components subject to change.

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