



# 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.

Monthly invoices should be provided  electronically (through the Group Portal) 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

Plan Name	<input type="checkbox"/> NJ S LBTY NG 15/60/2500/90 HMO PA 21
Network	Liberty
Gated/Non-Gated	N
Copayment	
a. PCP	\$15
b. Specialist	\$60 after ded
Network Deductible (Single)	\$2,500
Network Deductible (Family)	\$5,000
Network Maximum Out of Pocket (Single)	\$8,550
Network Maximum Out of Pocket (Family)	\$17,100
Network Coinsurance	90%
Outpatient Facility	
Freestanding	50% after ded
Hospital	50% after ded
Inpatient Facility per day	\$250 per day after ded up to \$1,250
Emergency Room	\$100 then 50% after ded
Prescription Drug (Mail Order is 2x retail amount)	\$10/\$50/50% SpRx:\$10/20% to \$150/50% to \$500

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.