

New York Small Group Application and Annual Certification Form Oxford Health Insurance, Inc. (OHI)

Freedom Plan® PPO
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Liberty PlanSM Gated PPO

Liberty PlanSM Gated EPO
Oxford EPO
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Oxford EPO HSA
Primary Advantage

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This Application and Annual Certification Form is used for renewals of Oxford small group health coverage and for groups that are being moved from their large group policy into an Oxford small group replacement plan, due to a change in group size.

Employer Name: _____ Group Number: _____

Address (Street): _____

City, State, ZIP Code: _____

INFORMATION REQUIRED FOR CERTIFICATION

Questions (All questions must be answered)

If the number of Full-time Equivalent Total Number of Employees (FTEs) exceeds 100 over the prior calendar year, you are not a small group in New York, and would be considered a large group. We will contact you to offer a large group renewal proposal. If you have less than 100 FTEs but have more than 100 eligible employees, we will reach out to you to determine whether you are eligible for a large or small group product. You may contact your broker or Oxford Sales Representative to begin this process.

1. Enter the Prior Calendar Year Full-time Equivalent Total Number of Employees _____
(This information will be used to determine whether you are a small group.)

For purposes of determining your number of full-time equivalent employee count over the prior calendar year, please use the following calculation:

- (1) For each month during the calendar year, count all full-time employees. (A full-time employee is one who works an average of 30 or more hours per week.)
- (2) For each month during the calendar year, count all HOURS worked by part-time employees and divide by 120.
- (3) Add the number resulting from (2) to the number resulting from (1) for each month during calendar year.
 - a) Only if the total number is equal to or exceeds 101 employees, then you must verify that “seasonal workers” who worked less than 120 days were not included and remove them from the calculation.
 - b) A “seasonal worker” is one who performs labor or services on a seasonal basis as defined by the Federal Secretary of Labor, including retail workers employed only during a holiday season.
- (4) Divide the total number of (3) by 12. If the business was new and did not operate for all of the previous calendar year, divide by the number of months of data that were used.

2. Enter the Prior Calendar Year Average Total Number of Employees _____
(This question is included for Department of Health and Human Services reporting purposes only and does not determine group size.)

Under Health Care Reform law, the average total number of employees means the average number of employees employed by the company during the preceding calendar year. An employee is any person whose work is controlled and directed by the employer (also known as common law employees). Employees may work full-time, part-time and on a seasonal basis. Individuals do not have to qualify for medical coverage to be considered employees. Although employees generally will receive a W-2, include in your employee count common law employees who may not always get W-2s.

To calculate the annual average, add all the monthly employee totals together then divide by the number of months you were in business last year (usually 12 months). When calculating the average, consider all months of the previous calendar year regardless of whether you had coverage with us, had coverage with a previous carrier or were in business but did not offer coverage. Use the number of employees at the end of the month as the "monthly value" to calculate the year average. If you are a newly formed business, calculate your prior year average using only those months that you were in business. Use whole numbers only (no decimals, fractions or ranges).

3. How many eligible employees does this group have? _____

Eligible employees: Active permanent employees of the employer and of all subsidiaries or affiliates of a corporate employer who work **20 or more hours** per week and are eligible for health benefits through the employer's group health plan. Eligible employees do not include:

- Any person who does not meet the common law employee definition under Department of Labor and Internal Revenue Code rules, or
- Any former employee who is covered through retiree benefits, COBRA, or state continuation.

An employer may elect to offer coverage to a class of eligible employees based on conditions pertaining to employment: geographic situs of employment, earnings, method of compensation, hours, and occupational duties. Employees who work less than 20 hours per week are not eligible employees and may not enroll in any Oxford product. If coverage is limited to specific class(es) of employees, the class(es) must be specified below.

Please list classes of employees eligible for coverage: _____

If the employer does not offer group health coverage to all eligible employees, eligible employees should include (1) the number of eligible employees who work in the state of New York, and (2) if the employer offers Oxford coverage to out-of-state employees, the number of out-of- state eligible employees.

4. Total number of eligible employees being offered Oxford coverage _____

Of the eligible employees who work 20 or more hours per week, please count all employees who will be offered coverage under this policy.

Groups seeking to purchase insurance, also must meet the minimum participation requirements for coverage, except during the annual open enrollment period from November 15th - December 15th. If minimum participation requirements were not applied on issuance, they will not be applied on renewal. Please review the *New York Small Group (1-100) Underwriting Requirements* document contained with the renewal materials for details on our minimum participation requirements.

5. If the employer offers retiree coverage, how many eligible retired former employees does the group have? _____

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

6. Total number of employees and former employees enrolling at renewal: _____
 Enrolling means the total number of eligible employees, COBRA or state continuation enrollees, and retired employees (if applicable) accepting coverage in any Oxford product.
- a) Of those former employees enrolling at renewal, how many are retired? _____
- b) Of those former employees enrolling at renewal, how many will enroll through COBRA or state continuation? _____
7. Total number of eligible employees waiving coverage for the following reasons:
- a) A spouse's health benefit plan _____
- b) Medicare _____
- c) Medicaid _____
- d) Veteran's coverage _____
- e) Parental waiver _____
- f) All other waivers (include number of eligible employees enrolling in other employer sponsored HMO or insurance coverage) _____
8. Is your group subject to COBRA (20 or more total employees during at least 50 percent of the working days in the previous calendar year)? Yes No
9. Is your group offering other group health insurance coverage? Yes No
- If Yes, please list the name of other carrier, type of coverage, effective dates, and the number of employees enrolled.
- Carrier: _____ Type of coverage: _____
- Effective dates: _____ to _____ Number of employees enrolled: _____
10. Total number on payroll, regardless of eligibility, hours worked, work location, or other coverage: _____
11. Subject to ERISA? Yes No (Most private sector plans are ERISA plans.)
 If No, please indicate appropriate category:
- | | |
|---|---|
| <input type="checkbox"/> Church (Additional information needed) | <input type="checkbox"/> Federal Government |
| <input type="checkbox"/> Indian Tribe – Commercial Business | <input type="checkbox"/> Non-Federal Government (State, Local or Tribal Gov.) |
| <input type="checkbox"/> Foreign Government/Foreign Embassy | <input type="checkbox"/> Non-ERISA Other _____ |
12. Does your group sponsor a plan that covers employees of more than one employer? Yes No
 If you answered Yes, then indicate which of the following most closely describes your plan:
- | | |
|---|---|
| <input type="checkbox"/> Professional Employer Organization (PEO) | <input type="checkbox"/> Governmental |
| <input type="checkbox"/> Multiple Employer Welfare Arrangement (MEWA) | <input type="checkbox"/> Church |
| <input type="checkbox"/> Taft Hartley Union | <input type="checkbox"/> Employer Association |
13. Is your group a Professional Employer Organization (PEO) or Employee Leasing Company (ELC), or other such entity that is a co-employer with your client(s) or client-site employee(s)? Yes No
14. Do you currently utilize the services of a Professional Employer Organization (PEO) or Employee Leasing Company (ELC), Staff Leasing Company, HR Outsourcing Organization (HRO), or Administrative Services Organization (ASO)? Yes No
15. Do you have common ownership with any other businesses? Yes No
 If you own multiple companies, or a parent-subsidiary relationship exists between your company and another, this may indicate common ownership of businesses.

16. UnitedHealthcare's Leave of Absence (LOA) Policy; Eligibility for Medical Coverage

If the employee is on an employer approved leave of absence and the employer continues to pay required medical premiums, the coverage will remain in force for: (1) No longer than 13 consecutive weeks for non-medical leaves (i.e. temporarily laid-off). (2) No longer than 26 consecutive weeks for a medical leave. Coverage may be extended for a longer period of time, if required by local, state or federal rules.

If the employee's medical coverage terminates under this LOA policy, the employee may exercise the rights under any applicable Continuation of Medical Coverage provision or the Conversion of Medical Benefits provision described in the Certificate of Coverage.

Do you continue medical coverage during a leave of absence (not including state continuation or COBRA coverage)?

Yes, we continue medical coverage during an approved leave of absence for full time* employees (as defined above).

No, we do not offer medical coverage during a leave of absence.

The Employer's decision to refuse to offer coverage cannot be based upon health status related factors.

Required Tax Documents

You must submit documents to confirm that your group meets participation requirements (does not apply to HMO and POS products) and is eligible for Small Group coverage. Please review the *New York Small Group (1-100) Underwriting Requirements document* contained with the renewal materials for details.

Examples of acceptable documents include a *Quarterly Combined Withholding, Wage Reporting and Unemployment Insurance Return Form (NYS-45), Form 11-20S and K1 Schedule C*. If you filed a consolidated tax return as an affiliated group, please provide your most recent *IRS Form 851*. See enclosed Instruction Sheet for details.

Applicant Agreement and Certification

I, the undersigned, on behalf of the above named company (the "Applicant") am submitting this Form in connection with the Applicant's renewal or application for a small group health plan and understand that the information provided will be used to determine eligibility for small group coverage, premium rates and other purposes. I confirm that all information gathered herein is accurately represented and complete, and that the Applicant is not aware of any information that was not disclosed. The Applicant understands that if information is not complete or is not provided in a timely manner, then health benefits coverage may not be offered or renewed and the Applicant may be required to reapply for coverage.

This Certification Form is an Application (groups moving from a large group policy to a small group policy) or amendment to the Small Group Application for coverage and will become part of the Group Policy and Group Enrollment Agreement issued by the Oxford entity underwriting your coverage. If I submit or update this information electronically through Oxford's Idea Management SystemSM (IDEA), the Applicant agrees that this Certification and any other documents or notices related to this renewal will be provided electronically through the electronic IDEA system. (The Applicant's renewal submission on this Form is referred to as the "Renewal Application".)

The Applicant understands that this Renewal Application and the premium rates are subject to 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. Oxford reserves the right to modify rates in the event a plan design must be modified as a result of any change, modification or clarification in law. Oxford also retains the right to correct typographical errors or discrepancies prior to the effective date of coverage, and take other actions (for example, due to a misrepresentation of a materials fact) as permitted by applicable state law.

The Applicant understands that these products are only available to cover the Applicant's eligible employees and dependents. The Applicant confirms that no more than 100 full-time equivalent employees and at least 1 full-time equivalent employee are employed.

The Applicant understands that the group's Renewal Application may be chosen for an audit to confirm the information provided. Audits may be conducted before or after renewal. If documents reviewed or submitted during an audit show that the information provided on an application was false or that the group does not meet underwriting requirements, the group will not be renewed (audit completed prior to renewal) or will be terminated (audit completed post renewal).

The Applicant understands that other audits may be conducted while the Group Policy and/or Group Enrollment Agreement is in effect and agrees that all documents or other information that may impact coverage or premiums will be available for inspection.

The Applicant hereby acknowledges and understands that this Renewal Application does not constitute any obligation by Oxford to offer coverage and no insurance will be effective unless and until the Renewal Application is formally accepted, in writing, by the Oxford entity underwriting the coverage. No contract of insurance is to be implied in any way on the basis of completion and/or submission of this Application.

If coverage is formally accepted, the Applicant understands that this Certification Form and all documents submitted (including, but not limited to, any member application forms and tax documents) will become part of the Group Policy and Group Enrollment Agreement issued by Oxford.

Any intentional material misrepresentation within the Application or other information supplied to support the renewal may subject the group to termination or other action permitted by law. If plan design changes are being requested as part of the renewal, the Applicant's Group Policy and Group Enrollment Agreement, Certificate of Coverage and Summary of Benefits will be updated to reflect the requested changes.

By signing below, the Applicant agrees to be bound by the terms and conditions of the Group Policy and Group Enrollment Agreement, including any requested changes. The plan documents (including, but not limited to, the application, the Renewal Application, policy certificate(s) and riders) will determine the contractual provisions, including procedures, exclusions and limitations relating to the plan, and will govern in the event they conflict with any benefits comparison, summary of coverage or other description of the plan.

The Applicant agrees to offer coverage to all eligible employees and that only those employees or former employees and their spouses or dependents who are eligible for coverage will be enrolled.

By signing below, you are signing the Renewal Application on behalf of the group renewing their coverage and stating that (1) I am the Applicant or the agent for the Applicant and am authorized to sign this Renewal Application, and (2) the Applicant will be legally bound by the terms and conditions of this application, this authorization and the plan documents.

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 five thousand dollars and the stated value of the claim for each violation.

Signature of Authorized Company Representative

Title

Date

Printed Name of Authorized Company Representative