Oxford Health Plans

# The Freedom Plan

Freedom of choice to receive care from any of the over 83,000 Oxford affiliated providers.

# Metro EPO

## Program Design: Exclusive Provider Option (EPO)

The EPO Plan design only provides benefits when you see in-network providers. In-network means you choose to see your regular network physician or an Oxford participating network specialist. Nor referral is needed to see a specialist. You are not covered for out-of-network expenses.

## Metro Plan Features

The Freedom Plan Metro℠ program is designed to reduce health insurance premiums for you and your employees. By sharing some of the expense as you utilize healthcare services, if you use them at all, you get to realize up-front premium savings.

## Alternative Medicine

**The Choice Is Yours** – Members can access a fully credentialed network of acupuncturists, chiropractors, massage therapists, yoga instructors and nutritionists at Oxford contracted rates or agreed upon fee discounts.

**Healthcare Assistance** – Oxford On-Call®, the 24-hour healthcare guidance service, is staffed by Registered Nurses.

**Self-Service at www.oxhp.com** – The interactive features of the Oxford web site empower Members to take a more active role in their healthcare and request educational materials.

## Eligibility/Renewability

**City Bar Members May Apply If:** You are an employer group of one or more; you are actively engaged in the duties of your profession at least 20 hours per week; and you work in New York State. Sole proprietors may enroll during annual open enrollment periods each April.

**Dependents Are Eligible To Apply, Provided They Are A Member's:** Lawful spouse or registered domestic partner; unmarried, dependent children under age 26.

**Young Adult Option:** Young adults through the age of 29 who do not have access to employer sponsored health insurance may continue their coverage through a parent's health coverage once they reach the maximum age of dependency. This allows an eligible dependent to purchase his or her parent's group coverage as an individual subscriber. To be eligible, the dependent child must be under age 30, not married, not insured or eligible for coverage as an employee or member under any employer sponsored plan and not be covered under Medicare.

**Permanent, Full-Time Employees Are Eligible If:** You are actively employed at least 20 hours per week; you work in New York State; and you work for an Association Member.

**Member/Employee Coverage Will Terminate When:** You are no longer working at least 20 hours per week; the period for which coverage has been paid ends; you are no longer an Association Member; you no longer work in New York; or you are no longer working full-time for an Association Member.

**Dependent Coverage Will Terminate When:** A person no longer qualifies as a dependent; the period for which coverage has been paid ends; or your coverage as an Association Member or employee ceases.

## General Facts

**Coordination Of Benefits** – The benefits of this plan will be coordinated with the benefits of any other group health plan to which the individual is entitled.

Medicare is the primary coverage and Oxford Health Plans is secondary for employees with Medicare in firms with fewer than 20 employees.

**Preexisting Conditions** – A preexisting condition is a disease or a physical condition for which: a) a Member sought treatment, diagnosis or medical advice within six months immediately prior to becoming covered; or b) treatment, diagnosis or medical advice was actually recommended or received within six months immediately prior to becoming covered. However, credit will be given if you are covered by a qualified plan of coverage prior to enrolling in this program as required by law.

**Medically Necessary** – The benefits of this program shall be provided only to the extent that services are determined to be medically necessary. Oxford defines "medically necessary" as those services or supplies provided by a hospital, skilled nursing facility, physician or other provider, required to identify or treat your illness or injury that is determined by Oxford to be: a) consistent with the symptoms or diagnosis and treatment of your condition; b) appropriate with regard to standards of good medical practice; c) not solely for your convenience or that of any provider; and d) the most appropriate supply or level of service that can safely be provided. For inpatient services, it further means that your condition cannot safely be diagnosed or treated on an outpatient basis.

## How To Apply

Please complete each question on the application and return it to Marsh. For more information, call **888-882-2269.**

Sponsored by:

NEW YORK CITY BAR

Underwritten by:

UnitedHealthcare

OXFORD

MARSH

58712 (1/12) d/b/a in CA Seabury & Smith Insurance Program Management
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777 S. Figueroa St., Los Angeles, CA 90017 • 888-882-2269 • NYCBar.Insurance@marsh.com • www.NYCBAMemberInsurance.com

## About Our Role and Compensation

The New York City Bar Association has selected Oxford Health Plans for this insurance program. Alternative insurance products may be available in the insurance market place. Marsh/Seabury & Smith Insurance Program Management is providing this single insurer option on behalf of the New York City Bar Association. In accordance with industry custom, we are compensated through commissions that are calculated as a percentage of the insurance premiums charged by insurers. We may also receive additional monetary and nonmonetary compensation from insurers, or from other insurance intermediaries, which may be contingent upon volume, profitability or other factors. This compensation may include payment from insurers for marketing related expenses or investments in technology. Our compensation may vary depending on the type of insurance purchased and the insurer selected. We will provide you additional information about our compensation and information about alternative quotes, upon your request. You may obtain this information by referring to https://www.personal-plans.com/disclosure and entering the security code E120518441445 or call us at 1-888-206-5088 for specific details.

UnitedHealthcare OXFORD

**OXFORD HEALTH INSURANCE (NY), INC.**
**EXCLUSIVE PLAN METRO (EPO)**
**SUMMARY OF COVERAGE**
**FREEDOM NETWORK**
**NYCBA**

| BENEFIT | | IN-NETWORK |
|---|---|---|
| **FINANCIAL** | | |
| Deductible: | Single | None |
| | Family | None |
| Coinsurance | | None |
| Maximum Out-of-Pocket: | Single | None |
| | Family | None |
| Maximum Lifetime Benefit Per Member | | Unlimited |
| Financial Accumulation Period: | | Calendar Year |
| **PREVENTIVE CARE** | | |
| Adult Preventive Care | | No Charge |
| Pediatric Preventive Care | | No Charge |
| Infant Preventive Care | | No Charge |
| Immunizations | | No Charge |
| **OUTPATIENT CARE** | | |
| Primary Care Physician office visits | | $20 copay per visit |
| Specialist office visits | | $40 copay per visit |
| Surgery** | | $200 per visit |
| Laboratory services | | No Charge at participating Labs |
| Radiology services** | | 50% copayment to max of $100 |
| **ALLERGY CARE** | | |
| Initial visit, and all subsequent visits | | $40 copay per visit |
| **HOSPITAL CARE** | | |
| Physician's and surgeon's services** | | No Charge |
| Semi-private room and board** | | $200 per day up to 5 days per calendar year |
| All drugs and medication** | | No Charge |
| **EMERGENCY CARE** | | |
| Ambulance Service | | No Charge |
| At hospital Emergency Room | | $200 copay, Waived if admitted |
| (If member is admitted to the Hospital, notification is required) | | |
| Emergency Care in Urgi-Center** | | $40 copay per visit |
| **MATERNITY CARE** | | |
| Prenatal and Post-natal care** | | $20 copay per initial visit |
| Hospital services for mother and child ** | | $200 per day up to 5 days per calendar year |
| **SHORT TERM REHABILITATION** | | |
| 60 consec. Inpatient days per condition per lifetime** | | $200 per day up to 5 days per calendar year |
| 60 Outpatient visits per condition per lifetime**" | | $40 copay per visit |
| **HOME HEALTH CARE** | | |
| 40 Home care visits per Calendar Year** | | $40 copay per visit |
| Physician house calls | | $40 copay per visit |
| **SKILLED NURSING FACILITY** | | |
| 200 days per Calendar Year ** | | $200 per day up to 5 days per calendar year |
| **SUBSTANCE ABUSE** | | |
| 7 days of Inpatient detox. per Calendar Year ** | | $200 per day up to 5 days per calendar year |
| 30 days of Inpatient rehab. per Calendar Year ** | | $200 per day up to 5 days per calendar year |
| 60 Outpt rehab. visits per Calendar Year ** | | $40 copay per visit |
| (combined w/office visits) | | |
| 60 office visits per Calendar Year ** | | $40 copay per visit |
| (combined w/outpatient visits) | | |

| BENEFIT | IN-NETWORK |
|---|---|
| **MENTAL HEALTH CARE** | |
| 30 days of Inpatient care per Calendar Year ** | $200 per day up to 5 days per calendar year |
| 30 Outpatient visits per Calendar Year** (combined w/office visits) | $40 copay per visit |
| 30 office visits per Calendar Year** (combined w/outpatient visits) | $40 copay per visit |
| **Biologically Based Mental Health Services & Services for Children with Serious Emotional Disorders** | |
| (Visits for Biologically based services will count toward Non-Biologically based service limits.) | |
| Inpatient Care** | $200 per day up to 5 days per calendar year |
| Outpatient Care** | $40 copay per visit |
| Office visits** | $40 copay per visit |
| **PRESCRIPTION DRUGS** | |
| (Includes Oral Contraceptives) | $100 Deductible (waived for Tier 1 Drugs) |
| Tier 1**** | $10 copayment |
| Tier 2**** | $30 copayment |
| Tier 3**** | $60 copayment |
| **ALTERNATIVE MEDICINE** | |
| Chiropractic care | $40 copay per visit |
| **HOSPICE CARE (210 days)** | |
| Inpatient care** | $200 per day up to 5 days per calendar year |
| Outpatient care** | $200 per visit |
| **HEARING AIDS** | |
| Coverage is limited to $1,500. Limited to a single purchase (including repair/replacement) every 3 years. | No Charge |
| **OTHER COVERAGE** | |
| Medical Supplies** | No Charge |
| Durable Medical Equipment** $1500 limit per Calendar Year Precertification for items $500 or more. | No Charge |
| Exercise Facility | |
| Subscriber | $200 reimbursement per 6 month period |
| Spouse | $100 reimbursement per 6 month period |

**DEPENDENT ELIGIBILITY:**
Eligible dependents include the employee's spouse and dependent children until the child reaches age 26
Benefits discontinue at the end of the Calendar Year.

Domestic Partners of the same or opposite sex are covered with proper documentation.
**These services require **precertification** through Oxford. You must call Oxford at 1-800-444-6222 at least 14 days in advance of request.
Mental health and substance abuse services can be precertified through Oxford's Behavioral Health Department by calling 1-800-201-6991.
****Prescription medication ordered through the Mail Order Drug Program are subject to 2.5 xapplicable retail pharmacy copays.

The Prescription Drug Benefit is based on a Per Contract Year Limit for any applicable deductibles and/or maximum limits.

**Please Note: This sample summary of coverage is provided for informational purposes only. The applicable Summary of Benefits will be issued to eligible enrolled members as part of the Certificate of Coverage. Coverage is subject to the terms and conditions of the Certificate.**
Refer to your Certificate of Coverage for a more complete listing of all benefits, limitations, and exclusions which include, among other services not authorized by Oxford cosmetic surgery, routine foot care, custodial care, personal comfort or convenience items, private or special duty nursing, learning and behavioral disorders Worker's Compensation, military service-related conditions or unless otherwise stated, dental services and vision correction services and supplies
**Please be advised this quote is for informational purposes only. The information contained herein is subject to both state regulatory and Oxford home office approval as appropriate.**

UnitedHealthcare OXFORD

**OXFORD HEALTH INSURANCE (NY), INC.**
**EXCLUSIVE PLAN METRO (EPO)**
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**FREEDOM NETWORK**
**NYCBA**

| BENEFIT | | IN-NETWORK |
|---|---|---|
| **FINANCIAL** | | |
| Deductible: | Single | None |
| | Family | None |
| Coinsurance | | None |
| Maximum Out-of-Pocket: | Single | None |
| | Family | None |
| Maximum Lifetime Benefit Per Member | | Unlimited |
| Financial Accumulation Period: | | Calendar Year |
| **PREVENTIVE CARE** | | |
| Adult Preventive Care | | No Charge |
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Refer to your Certificate of Coverage for a more complete listing of all benefits, limitations, and exclusions which include, among other services not authorized by Oxford cosmetic surgery, routine foot care, custodial care, personal comfort or convenience items, private or special duty nursing, learning and behavioral disorders Worker's Compensation, military service-related conditions or unless otherwise stated, dental services and vision correction services and supplies
**Please be advised this quote is for informational purposes only. The information contained herein is subject to both state regulatory and Oxford home office approval as appropriate.**

UnitedHealthcare®

OXFORD®

New York City Bar Association (AB 3087)

freedom plan

metro℠

# NY Small Group Application (OHI) Oxford Health Insurance Inc.

**Mail to: Marsh, Attn: Association Department, 777 South Figueroa Street, Los Angeles, CA 90017**
along with a check made payable to Marsh for the first month's premium.

58712

## I. GENERAL INFORMATION — Sole Proprietors

1. **Full legal name of firm:**

2. **Address of firm:**
(Street Address
City, State, Zip Code)
**No P.O. Box**

County:

3. **Plan Administrator/Contact:**

   a. Name

   b. Title

   c. Address:
   (If it differs from address of firm; cannot be a P.O. Box)

   City, State, Zip

   d. Phone Number

   e. Fax Number

   f. E-mail Address

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

   a. Name

   b. Title

   c. Address:
   (If it differs from address of firm; cannot be a P.O. Box)

   City, State, Zip

   d. Phone Number

   e. Fax Number

5. **Full legal name of each subsidiary and/or affiliated company whose employees are to be covered (if applicable):**

6. **Nature of business:**

7. **SIC Code:** 8111

8. **Tax identification number:**

Name of Company:_____

## II. ADMINISTRATIVE INFORMATION

**The term "coverage" means the benefits provided by Oxford, pursuant to the Group Certificate.**

1. **Effective date:** We request that this coverage be effective: _____.
   (Month / Day=1st / Year)
2. **Anniversary date:** April 1st
3. **Open enrollment period:** The open enrollment period will be the month prior to your anniversary date. The open enrollment effective date will be the first of the month following the period.
4. **Total Number of Employees:**_____ **/ Number of Temporary/Contracted Workers:**_____
5. **Employee Eligibility:** All full-time, permanent employees who work at least 20 hours per week (**minimum 20 hours/week**) are eligible.
6. **Number of Eligible Employees:** Active Employees_____
7. **Number of Employees** enrolling with Oxford Health Plans, with the new group application_____
8. **Number of Waivers** for health coverage submitted_____
9. **Continuation of Coverage:** Are you enrolling any former employees under COBRA or State Continuation Provisions? ❑ Yes ❑ No

   If yes, how many?_____

***Eligibility & Termination: the employee will become eligible on the latter of the effective date of this plan or the date selected below*** (check appropriate date).

### CLASS I

**Definition of Class I** All Full-Time

_____

**a) Waiting period** 30 **days from date of hire.**

**Eligibility**

☒ First of the month after the employee completes the waiting period.

**Termination**

On the last day of the calendar month in which employees' employment terminates.

**b) Should the waiting period be waived for rehire?**

☒ Yes ❑ No

(if rehired within 2 months).

### CLASS II

**Definition of Class II** _____

_____

**a) Waiting period**_____**days/months from date of hire.**

**Eligibility**

❑ First of the month after the employee completes the waiting period.

**Termination**

On the last day of the calendar month in which employees' employment terminates.

**b) Should the waiting period be waived for rehire?**

❑ Yes ❑ No

(if rehired within _____ months).

Name of Company:_____

## III. PLAN DESIGNS

| Freedom Network: | ❑ Metro Option 4 | ❑ Metro Option 5 | ❑ Option 6 |
|---|---|---|---|
| **1. Copayment:** | $25 per visit for PCP<br>$40 per visit for specialist | $15 per visit for PCP<br>$25 per visit for specialist | $25 per visit for PCP<br>$40 per visit for specialist |
| **2. In-Network deductible*:** | None | None | $1,000 single; $2,500 family |
| **3. Out-of-Network deductible*:** | $2,000 single; $6,000 family | $2,000 single; $6,000 family | $2,000 single; $5,000 family |
| **4. Coinsurance: In-Network**<br>**Out-of-Network** | None<br>Plan 70% / Member 30% | None<br>Plan 70% / Member 30% | Plan 80% / Member 20%<br>Plan 60% / Member 40% |
| **5. Annual Out-of-Pocket Maximum:**<br>(Out-of-Network, including deductible) | $5,000 Single<br>$15,000 Family | $5,000 Single<br>$15,000 Family | $6,000 Single<br>$15,000 Family |
| **6. Out-of-Network reimbursement:** | 140% of Medicare | 140% of Medicare | 140% of Medicare |
| **7. Pharmacy benefit:** Tier 1/2/3<br>Deductible:<br>Mail Order (90 day supply): | $10 / $30 / $60<br>$100 per contract yr. 4/1 – 3/31<br>$25 / $75 / $150 | $10 / $30 / $60<br>$100 per contract yr. 4/1 – 3/31<br>$25 / $75 / $150 | $10 / $30 / $60<br>$100 per calendar yr.<br>$25 / $75 / $150 |
| **8. Inpatient facility copay:** (In-Network) | $500 copay per day<br>($2,500 Calendar year max.) | $250 copay per day<br>($1,250 Calendar year max.) | Deductible and 20% copayment |
| **9. Outpatient surgery copay:** (In-Network) | $500 copay | $250 copay | Deductible and 20% copayment |
| **10. Emergency room copay:** (In-Network) | $200 | $200 | $200 |

* Deductibles are on a calendar year basis and restart each January 1, except pharmacy deductibles for Metro 4 and 5, and the Metro EPO plans which are 4/1 – 3/31 of each year.

**Please note: Out-of-Network Reimbursement Amount.** Payments to out-of-network providers are based on 140% of the standard Medicare rates which may be below what your provider charges. You are responsible for your coinsurance portion plus any additional amount charged by a non-network provider. If a Member receives services from a facility or physician who does not participate in the Oxford Health Plans or UnitedHealthcare network of providers, claim payment may be made directly to the covered member instead of to the non-participating provider.

| Freedom Network: | ❑ Metro EPO 20-40 | ❑ Metro EPO 25-50 |
|---|---|---|
| **1. Copayment:** | $20 per visit for PCP<br>$40 per visit for specialist | $25 per visit for PCP<br>$50 per visit for specialist |
| **2. In-Network deductible*:** | None | None |
| **3. Out-of-Network deductible*:** | Not covered | Not covered |
| **4. Coinsurance:** | None | None |
| **5. Annual Out-of-Pocket Maximum:** | Not covered | Not covered |
| **6. Out-of-Network reimbursement:** | Not covered | Not covered |
| **7. Pharmacy benefit:** Tier 1/2/3<br>Deductible:<br>Mail Order (90 day supply): | $10 / $30 / $60<br>$100 per contract yr. 4/1 – 3/31<br>$25 / $75 / $150 | $10 / $30 / $60<br>$100 per contract yr. 4/1 – 3/31<br>$25 / $75 / $150 |
| **8. Inpatient facility copay:** (In-Network) | $200 per day<br>($1,000 Calendar year max.) | $300 per day<br>($1,500 Calendar year max.) |
| **9. Outpatient surgery copay:** (In-Network) | $200 copay | $300 copay |
| **10. Emergency room copay:** (In-Network) | $200 | $200 |

**EPO:** No benefits are provided for out-of-network services.

Name of Company:_____

**Group location and number of Members in each location:**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| ❑ Bronx | _____ | ❑ Queens | _____ | ❑ Rockland | _____ | ❑ Staten Island | _____ |
| ❑ Brooklyn | _____ | ❑ Westchester | _____ | ❑ Putnam | _____ | ❑ Nassau | _____ |
| ❑ Manhattan | _____ | ❑ Suffolk | _____ | ❑ Orange | _____ | | |

## IV. RATE INFORMATION

**Monthly Rates:** All new groups are subject to the 4 tier rate structure indicated below. Rates must be included in the spaces below for application processing.

| | Single | Couple | Parent/Child | Family |
|---|---|---|---|---|
| $ | | | | |

## V. YOUNG ADULT OPTION

❑ Add Over-Age Child as a Dependent Age 29 and Under (Young Adult)

Signature of Young Adult:_____

Member Signature:_____

## VI. BROKER/AGENT INFORMATION

1. **Full legal name of firm:** Seabury & Smith
Insurance Program Management
CA Ins. Lic. #0633005
AR Ins. Lic #245544

2. **Address for firm:** Marsh
attn: Association Department
777 South Figueroa Street
Los Angeles, CA 90017

3. **Telephone/Fax Number** 888-882-2269
Fax: 213-346-5946
E-mail: NYCBar.Insurance@marsh.com

4. **Broker ID Code:** BC9522

58712 (1/12) d/b/a in CA Seabury & Smith Insurance Program Management • CA Ins. Lic. #0633005 • AR Ins. Lic. #245544
©Seabury & Smith, Inc. 2012 • 777 South Figueroa Street, Los Angeles, CA 90017
888-882-2269 • NYCBar.Insurance@marsh.com • www.NYCBAMemberInsurance.com

### About Our Role and Compensation

The New York City Bar Association has selected Oxford Health Plans for this insurance program. Alternative insurance products may be available in the insurance market place. Marsh/Seabury & Smith Insurance Program Management is providing this single insurer option on behalf of the New York City Bar Association. In accordance with industry custom, we are compensated through commissions that are calculated as a percentage of the insurance premiums charged by insurers. We may also receive additional monetary and nonmonetary compensation from insurers, or from other insurance intermediaries, which may be contingent upon volume, profitability or other factors. This compensation may include payment from insurers for marketing related expenses or investments in technology. Our compensation may vary depending on the type of insurance purchased and the insurer selected. We will provide you additional information about our compensation and information about alternative quotes, upon your request. You may obtain this information by referring to https://www.personal-plans.com/disclosure and entering the security code E120518441445 or call us at 1-888-206-5088 for specific details.

Name of Company:_____

## VII. CONSENT

**AUTHORIZATION FOR BROKER TO ACT AS BENEFITS ADMINISTRATOR**

The undersigned hereby requests Oxford Health Plans to accept the Broker or General Agent named above as an authorized Benefits Administrator for purposes of processing any enrollment transactions for my company's Oxford 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):

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

_____ Remain in place until_____.
(Date)

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.

## 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_____.

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**Full legal name of firm:**

The above named company confirms that we employ no more than 50 full-time non-union employees and no fewer than 1 full-time non-union employees. I understand that 1099-compensated individuals are not eligible for group coverage with Oxford Health Insurance unless they are considered sole proprietors. 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.

X_____

Signature of Authorized Officer of the Company Title

_____

Witness

# New York Member Enrollment Form – OHI

UnitedHealthcare® OXFORD®

**MAILING ADDRESS: Marsh,** attn: Association Department, 777 South Figueroa Street, Los Angeles, CA 90017 • 888-882-2269

## A. Group Information (To be completed by the employer)

Please print neatly using black or blue ballpoint pen • ALL DATES MUST BE: MM/ DD/YYYY

| Group Number | Group Name | Plan CSP | Billing Group | Date of Hire | Effective Date | Occupation |
|---|---|---|---|---|---|---|
| AB 3087 | | | | / / | / / | |

☐ On Leave of Absence ☐ Retired
☐ Must work min. 20 hrs/week ☐ Disabled

COBRA/Young Adult/SC Qualifying Event | Event Date / /

**Employer Signature** X | Date / /

## B. Applicant Details (To be completed by the employee)

| | Employee/Subscriber | Spouse | Child | Child |
|---|---|---|---|---|
| Social Security Number: | | | | |
| Last Name: | | | | |
| First Name, Middle Initial: | | | | |
| Date of Birth: (MM/DD/YYYY) | / / | / / | / / | / / |
| Gender and Disability Status: (Check appropriate boxes.) | ☐ M ☐ F / ☐ Disabled | ☐ M ☐ F / ☐ Disabled | ☐ M ☐ F / ☐ Disabled | ☐ M ☐ F / ☐ Disabled |
| Primary Care Physician (PCP) ID Number: PCP Name: (If an existing patient of PCP, check "Yes".) | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes |
| Check all that apply: | | ☐ Domestic Partner | ☐ Under age 26 ☐ Young Adult | ☐ Under age 26 ☐ Young Adult |
| **Prior Carrier** (List coverage prior to this.) ☐ Same for all — Carrier: / Policy Number: / From Date / Thru date:: | / / / / | / / / / | / / / / | / / / / |

## C. Coordination of Benefits

| | Employee/Subscriber | Spouse | Child | Child |
|---|---|---|---|---|
| **Medicare Coverage** — Check appropriate box and list effective date: | ☐ Part A / / ☐ Part B / / ☐ Part D / / | ☐ Part A / / ☐ Part B / / ☐ Part D / / | ☐ Part A / / ☐ Part B / / ☐ Part D / / | ☐ Part A / / ☐ Part B / / ☐ Part D / / |
| **Pharmacy** ☐ Same for all — Policy Number: / Carrier: / Policy Holder: / Effective Date: / / Group Number: / BIN: / PCN: | BIN: PCN: | BIN: PCN: | BIN: PCN: | BIN: PCN: |
| **Medical** ☐ Same for all — Policy Number: / Carrier: / Policy Holder: / Effective Date: | / / | / / | / / | / / |

I understand that my enrollments and benefits are in accordance with those described in the Oxford Health Insurance Certificate. I understand that, in order to receive in-network benefits, I and any enrolled dependents must seek care through our Oxford affiliated primary care physician or through an Oxford-affiliated specialist physician with an authorized referral from the primary care physician if required. I further understand that if I do not adhere to these requirements, I will be eligible only for out-of-network health insurance coverage under the terms of the Certificate. 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, or conceals for the purpose of misleading, 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 such violation. I authorize any health provider or insurer to furnish Oxford any records concerning me or any enrolled member of my family for whom information is requested.

Employee's Address (Apt #)

City State Zip

**Employee's Signature** X | Date / /

NEW YORK CITY BAR