Oxford Benefit Management Group Enrollment Checklist

We've created this checklist to make doing business with Oxford Benefit Management® (OBM) convenient. All forms listed below are available on **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 first of each month.

- The employer must contribute at least 50% toward the employee's premium for Contributory plans and no more than 49% for the Voluntary plan.
- Groups enrolling in Contributory plans must have at least 75% of the active eligible employees enrolled, excluding those waived with spousal coverage.
- Groups enrolling in the voluntary plan must have at least 2 people enrolling to be eligible for coverage.
- **Basic Life:** If employees have medical coverage, Connecticut employees must work a minimum of 30 hours per week to receive the benefit. New Jersey employees must work a minimum of 25 hours per week to receive the benefit. New York employees must work a minimum of 20 hours per week to receive the benefit.

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

- A completed OBM Group Enrollment Checklist (this document).
- 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% 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: __________

Billing Representative Email Address:

____

☐ Check here to receive your premium invoice by email at the above email address. If unchecked, the invoice will be mailed to your billing address.

CONTINUED

UnitedHealthcare® Oxford

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: ____________________

Did your company have prior dental 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% of the employee's premium for Contributory plans and must not exceed 49% for the Voluntary plan.

Sales Representative Information

Sales Representative Name:

____

Email: ____________________

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

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: ____________________

____

CONTINUED

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: ____________________

____

Mail Submissions to:

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

Or email to:

OBM@ancillary-benefits.com

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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.

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