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: __________________

United Healthcare Oxford

continued

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

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/SSN: ______________

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/SSN: ____

License #: ____

Mailing address: ____

____

City: ____

State: _______________ ZIP code: _______________

Phone: ____

Fax: ____

Email: ____

GA signature: _______________________ Date: __________

Commission checks payable to: _______________________

____

Fax to:

732-676-2655

Or email to:

OBM@ancillary-benefits.com

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