UnitedHealthcare®
Oxford

Oxford Individual Product Required Documentation Sheet

All applications for Oxford Individual coverage require two proofs of residency. All documentation must be current and contain proof of physical residence address. Documents with a P.O. Box will not be accepted as proof of residence.

Below is a listing of acceptable forms of proof:

- Current utility or credit card bill issued in the past 90 days that shows your name at your current address. **Mail addresses to P.O. boxes are not accepted as proof of residence.**
- Current checking or savings account statement from a bank or credit union, issued in the past 90 days
- High school or college report card or transcript containing your address, issued in the last year
- Current lease or rental agreement showing your name as lessee or renter
- Driver's License/Learner Permit/Non-Driver ID Card – current/not expired
- Federal or State Income Tax W2 with Social Security number from current year
- Bank statement or cancelled check (with preprinted name and address) dated within past 90 days
- Electronically printed pay stub with name and address showing that payment is United States based
- Annual Social Security Statement for current year
- Assisted Living or Nursing Home Statement for current year
- Copy of credit card statement issued within past 90 days; credit card number should be blacked out
- Current proof of homeowners/renters insurance (e.g., policy, proof of claim)
- Federal or State Income Tax or Earning Statement (1099 or 1098) for current year
- Military Order still in effect
- Property or school tax bills or receipts for current year (must reflect current address both on mailing portion and portion stating what property is being taxed)
- Current Retirement Statement (e.g., 401(k))
- Current Social Security Insurance (SSI) Award Statement
- Unemployment Benefit Statement issued within past year
- Voter Registration Notification Card issued within past year
- Current Welfare Benefit Statement

All applications must be completed in full prior to submission. A Social Security number must be provided to consider an application complete. If an applicant does not have a Social Security number, then an alternative source of identification must be supplied.

Below is a sampling of alternative forms of identification:

- Valid Passport
- Valid Visa
- Valid Driver's License
- Valid Non-Driver ID

1- Complete application on page 4 in full, making sure to SIGN as well as choose a doctor.

2- Make copies of TWO(2) valid forms of RESIDENCY outlined above.
3- FAX or better EMAIL copies of application and residency proof to us at:
212-320-0222 or info@medicalsolutionscorp.com
4- Once we review and give you the OK, you must MAIL the application, (2) residency proofs and First months premium payable to Oxford Health Plans to:
Individual Product Department, 14 Central Park Drive, Hooksett, NH 03106

Call (855) 667-4621
www.medicalsolutionscorp.com

2016 New York Individual Plan Rates (Metro Network)

January 2016 – December 2016

Use the table below to determine your monthly rate for the Oxford Individual plan of your choice. Your rates are based on the plan you select. You must live, work or reside in our service area to be eligible to purchase coverage. The Oxford Metro Network service area includes Bronx, Brooklyn, Dutchess, Manhattan, Nassau, Orange, Putnam, Queens, Rockland, Staten Island, Suffolk, Sullivan, Ulster and Westchester counties.

	Oxford Standard Gated EPO $3500 Bronze	Oxford Standard Gated EPO HSA $4000 Bronze	Oxford Standard Gated EPO $2000 Silver	Oxford Standard Gated EPO $600 Gold	Oxford Standard Gated EPO Platinum
NETWORK	METRO	METRO	METRO	METRO	METRO
Office Visit Copayment	Not Applicable (50% coinsurance applies)	Not Applicable (50% coinsurance applies)	$30/$50 after deductible	$25/$40 after deductible	$15/$35
In-network Deductible	$3,500/$7,000	$4,000/$8,000	$2,000/$4,000	$600/$1,200	Not applicable
In-network Coinsurance	50%/50% to $6,850/$13,700	50%/50% to $6,450/$12,900	30%/70% to $5,500/$11,000	20%/80% to $4,000/$8,000	10%/90% to $2,000/$4,000
Pharmacy	$10/$35/$70 after deductible	$10/$35/$70 after deductible	$10/$35/$70	$10/$35/$70	$10/$30/$60

2016 Rates					
Single rate	$453.05	$454.10	$555.99	$656.30	$774.51
Parent / Child(ren) rate	$770.19	$771.98	$945.19	$1,115.71	$1,316.66
Couple rate	$906.11	$908.20	$1,111.99	$1,312.61	$1,549.02
Family rate	$1,291.20	$1,294.19	$1,584.59	$1,870.47	$2,207.36
Child only rate	$186.66	$187.09	$229.07	$270.40	$319.10
Dep 29 Rider					
Single rate	$113.72	$113.98	$139.55	$164.73	$194.40
Parent / Child(ren) rate	$193.32	$193.77	$237.24	$280.04	$330.48
Couple rate	$227.43	$227.96	$279.11	$329.47	$388.80
Family rate	$324.09	$324.84	$397.73	$469.49	$554.05
Two Children					
Child only rate	$373.32	$374.18	$458.14	$540.80	$638.20
Three or more Children					
Child only rate	$559.98	$561.27	$687.21	$811.20	$957.30

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www.medicalsolutionscorp.com

Oxford

Premium rates, plan designs, and/or the new Metro network have been filed and are subject to approval by regulators.

Oxford HMO products are underwritten by Oxford Health Plans (NY), Inc.

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Non-Grandfathered Plan

6394 Rev 37

New York Individual Plan Enrollment Application and Physician Selection Form

Application Instructions:

Please supply all the information requested on this form.

We want to process your application quickly, but, if this form is incomplete, we will have to return it.

- Be sure to include:
  - Dates of birth
  - Social Security numbers
  - Choice of Oxford physicians
  - Information on other coverage you have or have had (including Medicare)
- Attach proof of Applicant's (or responsible adult) address.
  Name and address on proof must be exactly the same as name and address in Section 1 inside.
  Acceptable proofs of address include photocopies of:
  - Valid New York State driver's license
  - Voter Registration Card
  - Current income tax return, current lease or current utility bill
  - If mailing address is different than street address, please provide mailing address under separate cover
- Select the type of coverage you want.
  Check the box for the level of coverage you want.
  Child only coverage is only available to applicants 20 years of age or younger.
  Note: If enrolling on child only coverage please list the youngest child as the applicant.
  The Dependent Coverage Extension through age 29 is available for all coverage options excluding child only.
- Applicant must sign the HMO Agreement in Section 3.
- Return the signed application.
  Keep a copy for your own records.
- Include the first month's premium, payable to Oxford Health Plans.

Note: The effective date you are eligible for is based on the date of the receipt of your application.

If you have any questions, call us at **1-800-969-7480.**

UnitedHealthcare Oxford

New York Individual Plan Enrollment Application and Physician Selection Form

1 Applicant Information

LAST NAME ______________________ FIRST NAME ______________________ MIDDLE INITIAL _______

STREET ADDRESS* ______________________________________ APT. NO ____________

CITY ______________________________ STATE____________ ZIP ______________

HOME PHONE ______________________________ WORK PHONE ______________________________

1. Are you eligible for health coverage under you or your spouse's employer plan? ❑ yes ❑ no
2. Are you or any dependents either eligible for, or currently on, Medicare for any reason? ❑ yes ❑ no
   a. If "Yes", please enter Name: ______________________
3. What kind of coverage do you want? ❑ NY Individual Platinum (HMO) ❑ NY Individual Gold (HMO) ❑ NY Individual Silver (HMO) ❑ NY Individual Bronze (HMO) ❑ NY Individual Platinum (POS)***
4. If 20 years or younger, do you want to opt for the child only plan? ❑ Yes ❑ No
   a. If yes, what coverage tier do you want? ❑ Single ❑ 2 children ❑ 3+ Children
5. What coverage tier do you want (leave blank if opting for child only plan)? ❑ Single ❑ Couple ❑ Parent/Children ❑ Family
6. Additional Benefit Options:
   a. Dependent Coverage Extension through age 29 ❑ Yes ❑ No
7. When do you want your coverage to begin? _________/_________/_________
   MONTH DAY YEAR

*If mailing address is different than street address, please provide mailing address under separate cover.

***THE NY INDIVIDUAL PLATINUM POS IS ONLY AVAILABLE TO APPLICANTS THAT WERE EXISTING OXFORD POS INDIVIDUAL MEMBERS AS OF THE PRODUCT WITHDRAWAL TERMINATED EFFECTIVE 12/31/2013.

2 Enrollment Information

LAST NAME	FIRST NAME	M.I.	SEX	BIRTH DATE	AGE	SOCIAL SECURITY NO.	PRIMARY CARE PHYSICIAN	OBSTETRICIAN/GYNECOLOGIST**
APPLICANT							NAME ID#	NAME ID#
SPOUSE							NAME ID#	NAME ID#
CHILD							NAME ID#	NAME ID#
CHILD							NAME ID#	NAME ID#
CHILD							NAME ID#	NAME ID#

**Women choose OB/GYN in addition to PCP.

Applicant must sign below

3 HMO Agreement

I understand that my enrollment and benefits are in accordance with those described in the applicable Oxford Health Plans (NY), Inc. HMO contract. I understand that, in order to qualify for HMO benefits, I and any enrolled dependents must choose an Oxford-affiliated physician for primary care and secure a referral from that physician to an Oxford-affiliated specialist physician for all specialist care. 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. A photographic copy of this authorization shall be as valid as the original. I certify that, as of the date my Oxford coverage becomes effective, neither I nor my spouse have Medicare or any other group medical coverage except for that named in this application. I certify that all the above information is correct.

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 be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

X ______________________________________
APPLICANT SIGNATURE DATE

Insurer Use Only ______________________________
DATE INITIALS ID#

Broker Information (if applicable)

Broker/Agency Name: MIllennium Medical Solutions Corp

Broker/Agency Code: BN1115

Writing Agent Code: BC9165

For Application Questions Call 1-800-969-7480

Pediatric Dental Essential Health Benefit

All Oxford Individual plans will include the required pediatric essential health benefits.

Please retain a copy for your records. Mail or express application to:

Individual Product Department
14 Central Park Drive
Hooksett, NH 03106

Don't forget!

- **Sign your application!**
- **Enclose proof of Applicant's address!**
- **Be sure to enclose first month's premium!**