Oxford Health Plans

Employer Verification Form for New York State Community Rated Groups

Oxford Health Plans (NY), Inc. • Oxford Health Insurance, Inc.

Mailing Address: P.O. Box 7081, Bridgeport, CT 06601-7081 **Corporate Address:** 800 Connecticut Ave., Norwalk, CT 06854 • 203-852-1442 • 800-444-6222

Company Name: _____

Address: _____

_____

Number of Employees Eligible for this Plan: _____

I confirm that the above-named company is complying and will comply with Oxford Health Plans eligibility requirements. Furthermore, the above named company acknowledges that it shall only enroll eligible employees and their eligible dependents as set forth in Oxford's enrollment policies.

The above named company confirms that we employ no more than 50 full-time non-union employees and no fewer than 2 full-time non-union employees. I understand that 1099-compensated individuals are not eligible for group coverage with Oxford Health Plans.

I hereby acknowledge and agree that the above statements are complete and true. I understand that omissions, misrepresentations or misstatements about employment history, group size or dependents of employees may result in one or all of the following:

1. Termination of our group coverage
2. Denial of claims
3. Reimbursement to Oxford on any claim paid on behalf of non-eligible persons

The above-named company also acknowledges responsibility for any administrative and/or legal costs incurred by Oxford to address any of these situations.

I will also make available to Oxford Health Plans any documentation required to demonstrate compliance with Oxford's enrollment policies upon Oxford's written request.

X _____ _____

SIGNATURE OF OWNER, PARTNER, OFFICER TITLE — DATE

_____

PLEASE PRINT NAME

X _____ _____

SIGNATURE OF OWNER, PARTNER, OFFICER TITLE — DATE

_____

PLEASE PRINT NAME