

# SONNY A. HENNING INSURANCE

9671 CASTLE WOODS COVE, INDIANAPOLIS, IN 46280 FAX 888-766-8288  
TOLL FREE 1-888-SONNY-32 (888-766-6932)

Thank you for your interest in our Health Plans. I have attached a more detailed description for the quoted program.

Please print the attached file and complete all application forms per the instructions. Paperwork and checks must be returned to:

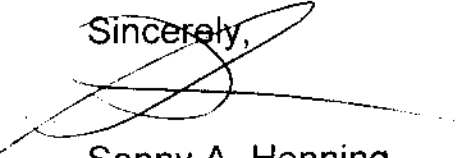
**SONNY A. HENNING  
SONNY HENNING INSURANCE  
9671 CASTLE WOODS COVE  
INDIANAPOLIS, IN 46280**

Please include a check, payable to the name instructed on the attached and be sure to include any requested tax documentation. **In addition, please include a check, payable to Sonny Henning Insurance in the amount of \$50.00 as a one time processing and handling fee.**

All forms must be received by the 15<sup>th</sup> of the month for a 1st of the month effective date.

If you have any questions, please feel free to call, toll free, at your convenience **1-888-SONNY-32 (1-888-766-6932)**.

Sincerely,



Sonny A. Henning  
SAH:ms  
Attachments

**BE SURE TO REMEMBER US FOR ALL YOUR LIFE AND  
HEALTH INSURANCE NEEDS, INCLUDING LIFE, HEALTH,  
DISABILITY, LONG TERM CARE AND OTHER SENIOR  
PRODUCTS.**

## **HOW TO GET STARTED?**

JUST FOLLOW THE SIMPLE INSTRUCTION BELOW AND MAIL  
ALL PAPERWORK AND CHECKS TO :

SONNY HENNING INSURANCE  
9671 CASTLE WOODS COVE  
INDIANAPOLIS, IN 46280

### **OXFORD – POS** **NEW YORK/NEW JERSEY**

**WWW.OXHP.COM**

- COMPLETE NCE MEMBERS APPLICATION FORM
- COMPLETE OXFORD ENROLLMENT FORM

**INLCUDE ONE CHECK FOR THE FIRST MONTH'S PREMIUM  
PLUS THE ANNUAL ADMINISTRATION FEE OF \$40,  
PAYABLE TO INTERNATIONAL BENEFIT ADMINSTRATORS**

**PLUS**

**A ONE TIME PROCESSING FEE OF \$50.00, PYABALE TO  
SONNY HENNING INSURANCE.**

**OXFORD – POS**  
**FREEDOM NETWORK**

**Rates effective through 5/1/05**

**SINGLE:       \$ 472.00**

**FAMILY:      \$ 1,057.00**

**Plus \$40 Annual Administration Fee**

**TAKE A LOOK AT THESE BENEFITS:**

**IN NETWORK**

**PCP/SPECIALIST - \$25/\$40 COPAY**

**\$50 – E.R. COPAY**

**\$250 HOSPITAL COPAY**

**RX - \$10/\$25/\$50 COPAY**

**OUT OF NETWORK**

**\$1,000/\$3,000 DEDUCTIBLE**

**70%/30%**

**MAX OOP - \$8,500/\$25,500 S/F**

**WWW.OXHP.COM**  
**FREEDOM NETWORK**



**OXFORD HEALTH PLANS, INC.**  
**FREEDOM PLAN CLASSIC**  
**SUMMARY OF COVERAGE**

Plan 1

BENEFIT		IN-NETWORK	OUT-OF-NETWORK
<b>FINANCIAL</b>			<b>Standard UCR</b>
Deductible:	Single Family	None	\$1000
Coinsurance		None	\$3000
Maximum Out-Of-Pocket:	Single Family	None	30%
Maximum Lifetime Benefit Per Member		Not Applicable	\$8500 (Including Deductible)
		Not Applicable	\$25500 (Including Deductible)
		Unlimited	Unlimited
<b>PREVENTIVE CARE</b>			
Physical Examination, Children		No Charge	Subject to Deductible & Coinsurance, \$300 maximum ***
Physical Examination, Adults		No Charge	Subject to Deductible & Coinsurance, \$300 maximum ***
Preventive dental for children (Under age 12)		No Charge	No Charge
<b>OUTPATIENT CARE</b>			
Primary Care Physician office visits ***		\$25 copay per visit *	Subject to Deductible & Coinsurance ***
Specialist Office Visits***		\$40 copay per visit *	Subject to Deductible & Coinsurance ***
Facility Surgery ***		\$100 copay	Subject to Deductible & Coinsurance ***
Laboratory services		At Participating Laboratories Only	Subject to Deductible & Coinsurance ***
		No Charge	
Magnetic Resonance Imaging (MRI)***		No Charge	Subject to Deductible & Coinsurance ***
<b>ALLERGY CARE</b>			
Initial visit, and all subsequent referral visits**		\$40 copay per visit	Subject to Deductible & Coinsurance
<b>HOSPITAL CARE</b>			
Physician's and surgeon's services ***		No Charge	Subject to Deductible & Coinsurance ***
Semi-private room and board ***		\$250 copay	Subject to Deductible & Coinsurance ***
All drugs and medication		No Charge	Subject to Deductible & Coinsurance
<b>EMERGENCY CARE</b>			
Ambulance service when Medically Necessary		No Charge	No Charge
At hospital emergency room (If member is admitted to the hospital, notification is required)		\$50 copay, waived if admitted	\$50 copay, waived if admitted
Emergency Care in Urgi-Center ***		\$40 copay per visit	Subject to Deductible & Coinsurance ***
<b>MATERNITY CARE</b>			
Prenatal and post-natal care ***		\$25 copay per initial visit	Subject to Deductible & Coinsurance ***
Hospital services for mother and child ***		\$260 copay	Subject to Deductible & Coinsurance ***
<b>ELECTIVE TERMINATION OF PREGNANCY</b>			
We pay a maximum benefit of \$350 per procedure, we cover one procedure per Member per contract year		No Charge	Subject to Deductible & Coinsurance ***
<b>SHORT TERM REHABILITATION</b>			
60 consec. inpatient days per condition / lifetime***		\$250 copay	Subject to Deductible & Coinsurance ***
90 outpatient visits per condition / lifetime		\$40 copay per visit	Subject to Deductible & Coinsurance
<b>HOME HEALTH CARE</b>			
Home care visits ***		\$40 copay per visit	Subject to 20% Coinsurance ***
Physician house calls		\$40 copay per visit *	Subject to Deductible & Coinsurance
<b>SKILLED NURSING FACILITY</b>			
30 days per calendar year ***		\$250 copay	Subject to Deductible & Coinsurance ***
<b>SUBSTANCE ABUSE</b>			
7 days of inpatient detox. per calendar year ***		\$250 copay	Subject to Deductible & 50% Coinsurance ***
30 days of inpatient rehab. per calendar year ***		\$250 copay	Subject to Deductible & 50% Coinsurance ***
60 outpatient rehab. visits per calendar year ***		No Charge	Subject to Deductible & Coinsurance ***

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
<b>MENTAL HEALTH CARE</b>		
30 days of inpatient care per calendar year ***	\$250 copay	IN-NETWORK BENEFIT ONLY
30 outpatient visits per calendar year ***	\$40 copay per visit	Subject to Deductible & 50% Coinsurance***
<b>CHIROPRACTIC CARE</b>		
Chiropractic care	\$40 copay per visit	Subject to Deductible & Coinsurance
<b>HOSPICE CARE (210 days)</b>		
Inpatient care***	\$250 copay	Subject to Deductible & Coinsurance ***
Outpatient care***	\$100 copay	Subject to Deductible & Coinsurance ***
<b>ADVANCED INFERTILITY TREATMENT (10,000 PER LIFETIME)</b>		
Specialist office visits***	\$40 copay per visit	IN-NETWORK BENEFIT ONLY
Outpatient facility services***	\$100 copay	IN-NETWORK BENEFIT ONLY
<b>EXERCISE FACILITY</b>		
Subscriber	\$100 reimbursement per 6 month period	\$100 reimbursement per 6 month period
Spouse	\$50 reimbursement per 6 month period	\$50 reimbursement per 6 month period
<b>DURABLE MEDICAL EQUIPMENT (\$1500 per Calendar Year)</b>		
When Medically Necessary and Pre-certified by Oxford in advance and ordered by an Oxford Participating Physician ***	No Charge	Subject to Deductible & Coinsurance ***
<b>MEDICAL SUPPLIES</b>		
	OUT-OF-NETWORK BENEFIT ONLY	Subject to Deductible & Coinsurance ***
<b>PRESCRIPTION DRUGS</b> (Includes Oral Contraceptives)		
Per Generic Prescription ****	\$10 Copay	Not Covered
Per Preferred Brand Name Prescription ****	\$25 Copay	Not Covered
Per Brand Name Prescription ****	\$50 Copay	Not Covered

**DEPENDENT ELIGIBILITY:**

Eligible dependents include the employee's spouse and dependent children until the child reaches age 19, or age 23 if a full time student. Benefits discontinue at the Calendar Year.

\* If the provider is your selected PCP, the lower copay will apply. If the provider is a Specialist, the higher copay applies (unless he/she has been authorized by OXHP as your PCP).

**Please note: referrals from PCP are required prior to utilizing Specialist for coverage to be considered In-Network.**

\*\*\* Please see your Certificate for procedures requiring precertification through Oxford. You must call Oxford at 800-444-6222 at least 14 days in advance of treatment to request precertification. Out-of-network Urgent Care, when properly precertified may be paid at member's copay.

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 two applicable retail pharmacy copays.

The Prescription Drug Benefit is based on a Per Contract Year Limit for any applicable deductible 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, Workers' Compensation, military service-related conditions, hearing aids, or, unless otherwise stated, dental services and vision correction services and supplies.

**NATIONAL CONGRESS OF EMPLOYEES'  
INDEPENDENT GUILD  
MEMBERS APPLICATION  
(Please Print)**

I hereby make application for membership in The National Congress of Employees' Independent Guild, agreeing to conform to its By-Laws and any Amendments thereof. I understand and authorize the use of my membership fees to defer administrative expenses and to further the goals and interest of the NCE, including political contributions to local and national candidates embodying the purposes of the NCE. Signing below constitutes an Agreement to conform to the NCE's by-laws and the terms and conditions of the set forth therein.

I understand and agree that said fees may be deducted from any monies remitted by me, whether referred to as dues, administrative fees or premium.

Participating Employee \_\_\_\_\_

Participating Employees Signature \_\_\_\_\_

Social Security # \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Employer \_\_\_\_\_

Address \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Date: \_\_\_\_\_ Employers Telephone #: \_\_\_\_\_



# Oxford Health Plans

Oxford Health Insurance Inc.

## New York Member Enrollment Form - OHI

Mailing Address: P.O. Box 7085, Bridgeport, CT 06601 • www.oxfordhealth.com

Please do not write in this area, for Oxford use only.

### To Be Completed By EMPLOYER

(Please Print)

NAME OF GROUP (EMPLOYER)		GROUP NUMBER	CONTRACT SPECIFIC PACKAGE (CSP)	BILLING GROUP (BG)
EMPLOYEE'S EFFECTIVE DATE OF COVERAGE MO. DAY YEAR	IS INDIVIDUAL COVERED UNDER COBRA? IF YES, QUALIFYING EVENT <input type="checkbox"/> YES <input type="checkbox"/> NO		DATE OF QUALIFYING EVENT MO. DAY YEAR	
DATE OF FULL-TIME EMPLOYMENT MO. DAY YEAR	AVERAGE NO. OF HOURS WORKED PER WEEK	EMPLOYEE OCCUPATION: <input type="checkbox"/> EXECUTIVE <input type="checkbox"/> MANAGEMENT <input type="checkbox"/> NON-MANAGEMENT <input type="checkbox"/> HOURLY <input type="checkbox"/> OTHER (PLEASE SPECIFY)		EMPLOYEE CLASSIFICATION <input type="checkbox"/> UNION <input type="checkbox"/> NON-UNION
X EMPLOYER SIGNATURE				DATE

### To Be Completed By EMPLOYEE

(Please Print)

SOCIAL SECURITY NO.	LAST NAME		FIRST NAME		MI	BIRTH DATE MO. DAY YEAR	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	HOME PHONE ( ) ( ) ( ) ( ) ( )	BUSINESS PHONE ( ) ( ) ( ) ( ) ( ) ( )
STREET ADDRESS			APT. NO.	CITY		STATE	ZIP		
WILL YOU HAVE ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, CARRIER NAME						NAME OF POLICY HOLDER		POLICY START DATE / /	
OXFORD CODE OF PRIMARY CARE PHYSICIAN SELECTED			ARE YOU AN EXISTING PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		PRIOR HEALTH INSURANCE INFORMATION: CARRIER NAME COVERAGE BEGIN DATE / / COVERAGE END DATE / /				
OXFORD CODE OF OB/GYN SELECTED (Female Members)			ARE YOU AN EXISTING PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO						

### EMPLOYEE'S Dependent Information

Please only complete for dependents who will be covered on your Oxford policy

(Please Print)

SPOUSE'S SOCIAL SECURITY NUMBER		SPOUSE'S LAST NAME		SPOUSE'S FIRST NAME		MI		
SPOUSE'S BIRTH DATE MO. DAY YEAR		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF MARRIAGE MO. DAY YEAR	SPOUSE'S EMPLOYER				
WILL YOU HAVE ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, CARRIER NAME						NAME OF POLICY HOLDER	POLICY START DATE / /	
OXFORD CODE OF PRIMARY CARE PHYSICIAN SELECTED			ARE YOU AN EXISTING PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		PRIOR HEALTH INSURANCE INFORMATION: CARRIER NAME COVERAGE BEGIN DATE / / COVERAGE END DATE / /			
OXFORD CODE OF OB/GYN SELECTED (Female Members)			ARE YOU AN EXISTING PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					
ELIGIBLE CHILD'S SOCIAL SECURITY NO.		ELIGIBLE CHILD'S LAST NAME		ELIGIBLE CHILD'S FIRST NAME		MI	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
ELIGIBLE CHILD'S BIRTH DATE MO. DAY YEAR		IS THIS DEPENDENT DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO	WILL YOU HAVE ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD? <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, CARRIER NAME				NAME OF POLICY HOLDER	POLICY START DATE / /
OXFORD CODE OF PRIMARY CARE PHYSICIAN SELECTED			ARE YOU AN EXISTING PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		PRIOR HEALTH INSURANCE INFORMATION: CARRIER NAME COVERAGE BEGIN DATE / / COVERAGE END DATE / /			
OXFORD CODE OF OB/GYN SELECTED (Female Members)			ARE YOU AN EXISTING PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					
ELIGIBLE CHILD'S SOCIAL SECURITY NO.		ELIGIBLE CHILD'S LAST NAME		ELIGIBLE CHILD'S FIRST NAME		MI	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
ELIGIBLE CHILD'S BIRTH DATE MO. DAY YEAR		IS THIS DEPENDENT DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO	WILL YOU HAVE ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD? <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, CARRIER NAME				NAME OF POLICY HOLDER	POLICY START DATE / /
OXFORD CODE OF PRIMARY CARE PHYSICIAN SELECTED			ARE YOU AN EXISTING PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		PRIOR HEALTH INSURANCE INFORMATION: CARRIER NAME COVERAGE BEGIN DATE / / COVERAGE END DATE / /			
OXFORD CODE OF OB/GYN SELECTED (Female Members)			ARE YOU AN EXISTING PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					
ELIGIBLE CHILD'S SOCIAL SECURITY NO.		ELIGIBLE CHILD'S LAST NAME		ELIGIBLE CHILD'S FIRST NAME		MI	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
ELIGIBLE CHILD'S BIRTH DATE MO. DAY YEAR		IS THIS DEPENDENT DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO	WILL YOU HAVE ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD? <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, CARRIER NAME				NAME OF POLICY HOLDER	POLICY START DATE / /
OXFORD CODE OF PRIMARY CARE PHYSICIAN SELECTED			ARE YOU AN EXISTING PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		PRIOR HEALTH INSURANCE INFORMATION: CARRIER NAME COVERAGE BEGIN DATE / / COVERAGE END DATE / /			
OXFORD CODE OF OB/GYN SELECTED (Female Members)			ARE YOU AN EXISTING PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					

If you have additional dependents, please use another enrollment form to provide the necessary information. In order to help us quickly process this form and avoid delays, please make sure all areas are properly filled out.

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.

X EMPLOYEE/APPLICANT SIGNATURE	DATE
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