OXFORD HEALTH PLANS®

A UnitedHealthcare Company

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? ❑ YES ❑ NO IF YES, QUALIFYING EVENT	DATE OF QUALIFYING EVENT MO. DAY YEAR

DATE OF FULL-TIME EMPLOYMENT MO. DAY YEAR	AVERAGE NO. OF HOURS WORKED PER WEEK	EMPLOYEE OCCUPATION: ❑ EXECUTIVE ❑ MANAGEMENT ❑ NON-MANAGEMENT ❑ HOURLY ❑ OTHER (PLEASE SPECIFY)	EMPLOYEE CLASSIFICATION ❑ UNION ❑ 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	❑ MALE ❑ 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? ❑ YES ❑ NO IF YES, CARRIER NAME	NAME OF POLICY HOLDER	POLICY START DATE / /

OXFORD CODE OF PRIMARY CARE PHYSICIAN SELECTED	ARE YOU AN EXISTING PATIENT? ❑ YES ❑ NO	PRIOR HEALTH INSURANCE INFORMATION: CARRIER NAME
OXFORD CODE OF OB/GYN SELECTED (Female Members)	ARE YOU AN EXISTING PATIENT? ❑ YES ❑ NO	COVERAGE BEGIN DATE / / COVERAGE END DATE / /

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	❑ MALE ❑ FEMALE	DATE OF MARRIAGE MO. DAY YEAR	SPOUSE'S EMPLOYER

WILL YOU HAVE ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD? ❑ YES ❑ NO IF YES, CARRIER NAME	NAME OF POLICY HOLDER	POLICY START DATE / /

OXFORD CODE OF PRIMARY CARE PHYSICIAN SELECTED	ARE YOU AN EXISTING PATIENT? ❑ YES ❑ NO	PRIOR HEALTH INSURANCE INFORMATION: CARRIER NAME
OXFORD CODE OF OB/GYN SELECTED (Female Members)	ARE YOU AN EXISTING PATIENT? ❑ YES ❑ NO	COVERAGE BEGIN DATE / / COVERAGE END DATE / /

ELIGIBLE CHILD'S SOCIAL SECURITY NO.	ELIGIBLE CHILD'S LAST NAME	ELIGIBLE CHILD'S FIRST NAME	MI	❑ MALE ❑ FEMALE

ELIGIBLE CHILD'S BIRTH DATE MO. DAY YEAR	IS THIS DEPENDENT DISABLED? ❑ YES ❑ NO	WILL YOU HAVE ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD? ❑ NO ❑ YES IF YES, CARRIER NAME:	NAME OF POLICY HOLDER	POLICY START DATE / /

OXFORD CODE OF PRIMARY CARE PHYSICIAN SELECTED	ARE YOU AN EXISTING PATIENT? ❑ YES ❑ NO	PRIOR HEALTH INSURANCE INFORMATION: CARRIER NAME
OXFORD CODE OF OB/GYN SELECTED (Female Members)	ARE YOU AN EXISTING PATIENT? ❑ YES ❑ NO	COVERAGE BEGIN DATE / / COVERAGE END DATE / /

ELIGIBLE CHILD'S SOCIAL SECURITY NO.	ELIGIBLE CHILD'S LAST NAME	ELIGIBLE CHILD'S FIRST NAME	MI	❑ MALE ❑ FEMALE

ELIGIBLE CHILD'S BIRTH DATE MO. DAY YEAR	IS THIS DEPENDENT DISABLED? ❑ YES ❑ NO	WILL YOU HAVE ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD? ❑ NO ❑ YES IF YES, CARRIER NAME:	NAME OF POLICY HOLDER	POLICY START DATE / /

OXFORD CODE OF PRIMARY CARE PHYSICIAN SELECTED	ARE YOU AN EXISTING PATIENT? ❑ YES ❑ NO	PRIOR HEALTH INSURANCE INFORMATION: CARRIER NAME
OXFORD CODE OF OB/GYN SELECTED (Female Members)	ARE YOU AN EXISTING PATIENT? ❑ YES ❑ NO	COVERAGE BEGIN DATE / / COVERAGE END DATE / /

ELIGIBLE CHILD'S SOCIAL SECURITY NO.	ELIGIBLE CHILD'S LAST NAME	ELIGIBLE CHILD'S FIRST NAME	MI	❑ MALE ❑ FEMALE

ELIGIBLE CHILD'S BIRTH DATE MO. DAY YEAR	IS THIS DEPENDENT DISABLED? ❑ YES ❑ NO	WILL YOU HAVE ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD? ❑ NO ❑ YES IF YES, CARRIER NAME:	NAME OF POLICY HOLDER	POLICY START DATE / /

OXFORD CODE OF PRIMARY CARE PHYSICIAN SELECTED	ARE YOU AN EXISTING PATIENT? ❑ YES ❑ NO	PRIOR HEALTH INSURANCE INFORMATION: CARRIER NAME
OXFORD CODE OF OB/GYN SELECTED (Female Members)	ARE YOU AN EXISTING PATIENT? ❑ YES ❑ NO	COVERAGE BEGIN DATE / / COVERAGE END DATE / /

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