Oxford Health Plans

Member Enrollment Form

Mailing Address: P.O. Box 7085, Bridgeport, CT 06601 ▪ 203-852-1442 ▪ 800-444-6222

Thank you for choosing Oxford Health Plans as the health plan for you and your family.

IMPORTANT!

In order to process the attached Member Enrollment form and begin coverage, all of the following information must be completed accurately and in its entirety:
INCOMPLETE FORMS WILL BE RETURNED.

By the Employer

- Group Number
- Contract Specific Package (CSP)
- Billing Group (BG)
- Date of Full-Time Employment
- Employer Signature
- Effective Date of Coverage

By the Employee

- Date of Marriage
- Date of Birth
- Social Security Numbers
- Primary Care Physician selections
- Information on other coverage that you or your spouse may have
- Signature at the bottom of the form, in Box A for HMO and HMO Select Plans or in both Box A and Box B for Freedom Plan, Liberty Plan, Freedom Plan Select, or Liberty Plan Select
- Mailing Address, including Zip Code

Note: Please press down firmly when completing this form.

If you have any questions, please feel free to call our Member Service Department at 800-444-6222 or 203-852-1442. Thank you for your cooperation.

Oxford Health Plans

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

Member Enrollment Form

Mailing Address: P.O. Box 7085, Bridgeport, CT 06601 • 203-852-1442 • 800-444-6222

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 Print)

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

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.

(A) I understand that my enrollment and benefits are in accordance with those described in the applicable Oxford Health Plans (NY), Inc. HMO Certificate. 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 Health Plans (NY), Inc. any records concerning me or any enrolled member of my family for whom information is requested. A photographic copy of this authorization shall be valid as the original.

X EMPLOYEE/APPLICANT SIGNATURE DATE

(B) I understand that in addition to the applicable Oxford Health Plans (NY) Inc. HMO Certificate, my enrollment and benefits are in accordance with those described in the applicable Oxford Health Insurance, Inc. Supplemental Freedom Plan Certificate. I understand that, in order to receive HMO 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. I further understand that if I do not adhere to these requirements for HMO benefits, I will be eligible only for traditional health insurance coverage under the terms of the Oxford Health Insurance, Inc. Supplemental Freedom Plan Certificate.

X EMPLOYEE/APPLICANT SIGNATURE DATE

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 concerning any fact material thereto commits fraudulent act, which is a crime and subjects such person to criminal and civil penalties.