

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					
OXFORD CODE OF OB/GYN SELECTED (Female Members)				ARE YOU AN EXISTING PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> 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		<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									
OXFORD CODE OF OB/GYN SELECTED (Female Members)				ARE YOU AN EXISTING PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		COVERAGE BEGIN DATE / /		COVERAGE END DATE / /							
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									
OXFORD CODE OF OB/GYN SELECTED (Female Members)				ARE YOU AN EXISTING PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		COVERAGE BEGIN DATE / /		COVERAGE END DATE / /							
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									
OXFORD CODE OF OB/GYN SELECTED (Female Members)				ARE YOU AN EXISTING PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		COVERAGE BEGIN DATE / /		COVERAGE END DATE / /							
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									
OXFORD CODE OF OB/GYN SELECTED (Female Members)				ARE YOU AN EXISTING PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		COVERAGE BEGIN DATE / /		COVERAGE END DATE / /							
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									
OXFORD CODE OF OB/GYN SELECTED (Female Members)				ARE YOU AN EXISTING PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> 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