



# Oxford Health Plans

## Member Enrollment Form

Mailing Address: P.O. Box 7085, Bridgeport, CT 06601 • 203-852-1442 • 800-444-6222 • [www.oxfordhealth.com](http://www.oxfordhealth.com)

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 (for Freedom Plan Access and Liberty Plan Access, no PCP selection is required)
- ✍ Information on other coverage that you or your spouse may have
- ✍ Signature at the bottom of the form
- ✍ Mailing Address, including Zip Code

\* Preexisting condition limitations apply to all Members with gaps in coverage of greater than 63 days in the 12 months prior to the Member's Enrollment Date. Please complete the enclosed "Health Coverage History Form."

**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 Insurance Inc.

## Member Enrollment Form

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

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.

X	EMPLOYEE/APPLICANT SIGNATURE	DATE
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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 shall also be subject to a civil penalty not to exceed \$5,000 dollars and the stated value of the claim for each violation.