



# Oxford Health Plans<sup>®</sup>

## Health Coverage History Form

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

Preexisting condition limitations apply to all New York Small Group employees and dependents with gaps in coverage greater than 63 days in the 12 months prior to the employee's hire date. This form will help us to determine whether you have any such gaps. Please complete and return this Health Coverage History Form with your Member Application.

### To Be Completed By Subscriber (Please Print)

LAST NAME										FIRST NAME & MI																									
STREET ADDRESS															APT. NO.					HOME PHONE					BUSINESS PHONE					COUNTY					
CITY										STATE					ZIP					SOCIAL SECURITY NO.					<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		BIRTH DATE			MO.		DAY		YEAR	

PLEASE PROVIDE THE FOLLOWING INFORMATION CONCERNING YOUR HEALTH COVERAGE DURING THE PAST 18 MONTHS PRIOR TO YOUR OXFORD EFFECTIVE DATE (CHECK ONE).

- NO PRIOR COVERAGE  
 ONE CARRIER PRIOR TO YOUR EFFECTIVE DATE WITH OXFORD  
 MULTIPLE CARRIERS PRIOR TO YOUR EFFECTIVE DATE WITH OXFORD

PRIOR CARRIER NAME:										POLICY/MEMBER NUMBER										DATE OF HIRE WITH PREVIOUS EMPLOYER										TYPE OF POLICY									
																														<input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> GROUP									
TYPE OF COVERAGE?										COVERAGE BEGIN DATE										COVERAGE END DATE																			
<input type="checkbox"/> HMO OR RELATED <input type="checkbox"/> TRADITIONAL/COMPREHENSIVE <input type="checkbox"/> OTHER																																							
PRIOR CARRIER NAME:										POLICY/MEMBER NUMBER										DATE OF HIRE WITH PREVIOUS EMPLOYER										TYPE OF POLICY									
																														<input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> GROUP									
TYPE OF COVERAGE										COVERAGE BEGIN DATE										COVERAGE END DATE																			
<input type="checkbox"/> HMO OR RELATED <input type="checkbox"/> TRADITIONAL/COMPREHENSIVE <input type="checkbox"/> OTHER																																							

**WILL YOU HAVE A SPOUSE AND/OR DEPENDENTS ON YOUR OXFORD POLICY?**  
 YES, I WILL HAVE A SPOUSE AND/OR DEPENDENTS ON MY POLICY.     NO, I WILL NOT HAVE A SPOUSE AND/OR DEPENDENTS ON MY POLICY.  
 IF YOU CHECKED "NO", PLEASE SKIP THE NEXT SECTION. IF YOU CHECKED "YES", PLEASE INDICATE BELOW THE HEALTH COVERAGE HISTORY OF YOUR SPOUSE AND EACH DEPENDENT ON YOUR POLICY, DURING THE 18 MONTHS PRIOR TO THEIR OXFORD EFFECTIVE DATE.

SPOUSE/DEPENDENT NAME															SOCIAL SECURITY NO.				

- CHECK ONE     NO PRIOR COVERAGE     ONE CARRIER PRIOR TO YOUR EFFECTIVE DATE WITH OXFORD  
 MULTIPLE CARRIERS PRIOR TO YOUR EFFECTIVE DATE WITH OXFORD

PRIOR CARRIER NAME:										POLICY/MEMBER NUMBER										DATE OF HIRE WITH PREVIOUS EMPLOYER									
TYPE OF COVERAGE										COVERAGE BEGIN DATE										COVERAGE END DATE									
<input type="checkbox"/> HMO OR RELATED <input type="checkbox"/> TRADITIONAL/COMPREHENSIVE <input type="checkbox"/> OTHER																													
PRIOR CARRIER NAME:										POLICY/MEMBER NUMBER										DATE OF HIRE WITH PREVIOUS EMPLOYER									
TYPE OF COVERAGE										COVERAGE BEGIN DATE										COVERAGE END DATE									
<input type="checkbox"/> HMO OR RELATED <input type="checkbox"/> TRADITIONAL/COMPREHENSIVE <input type="checkbox"/> OTHER																													

DEPENDENT NAME															SOCIAL SECURITY NO.				

- CHECK ONE     NO PRIOR COVERAGE     ONE CARRIER PRIOR TO YOUR EFFECTIVE DATE WITH OXFORD  
 MULTIPLE INSURANCE CARRIERS PRIOR TO YOUR EFFECTIVE DATE WITH OXFORD

PRIOR CARRIER NAME:										POLICY/MEMBER NUMBER										DATE OF HIRE WITH PREVIOUS EMPLOYER									
TYPE OF COVERAGE										COVERAGE BEGIN DATE										COVERAGE END DATE									
<input type="checkbox"/> HMO OR RELATED <input type="checkbox"/> TRADITIONAL/COMPREHENSIVE <input type="checkbox"/> OTHER																													
PRIOR CARRIER NAME:										POLICY/MEMBER NUMBER										DATE OF HIRE WITH PREVIOUS EMPLOYER									
TYPE OF COVERAGE										COVERAGE BEGIN DATE										COVERAGE END DATE									
<input type="checkbox"/> HMO OR RELATED <input type="checkbox"/> TRADITIONAL/COMPREHENSIVE <input type="checkbox"/> OTHER																													

DEPENDENT NAME															SOCIAL SECURITY NO.				

- CHECK ONE     NO PRIOR COVERAGE     ONE CARRIER PRIOR TO YOUR EFFECTIVE DATE WITH OXFORD  
 MULTIPLE CARRIERS PRIOR TO YOUR EFFECTIVE DATE WITH OXFORD

PRIOR CARRIER NAME:										POLICY/MEMBER NUMBER										DATE OF HIRE WITH PREVIOUS EMPLOYER									
TYPE OF COVERAGE										COVERAGE BEGIN DATE										COVERAGE END DATE									
<input type="checkbox"/> HMO OR RELATED <input type="checkbox"/> TRADITIONAL/COMPREHENSIVE <input type="checkbox"/> OTHER																													
PRIOR CARRIER NAME:										POLICY/MEMBER NUMBER										DATE OF HIRE WITH PREVIOUS EMPLOYER									
TYPE OF COVERAGE										COVERAGE BEGIN DATE										COVERAGE END DATE									
<input type="checkbox"/> HMO OR RELATED <input type="checkbox"/> TRADITIONAL/COMPREHENSIVE <input type="checkbox"/> OTHER																													

IF YOU NEED ADDITIONAL SPACE TO LIST YOUR DEPENDENTS, ATTACH A SHEET OF PAPER WITH THE INFORMATION TO THIS FORM.

TO THE BEST OF MY KNOWLEDGE, THE INFORMATION SHOWN ABOVE IS TRUE AND COMPLETE. I UNDERSTAND THAT FAILURE TO COMPLETE THIS FORM MAY RESULT IN DELAYED OR DENIED CLAIM PAYMENT FOR SERVICES RENDERED.

X \_\_\_\_\_

SIGNATURE OF SUBSCRIBER \_\_\_\_\_ DATE \_\_\_\_\_