



# Oxford Health Plans

## Member Enrollment Form

**Mailing Address:** P.O. Box 7085, Bridgeport, CT 06601 • 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. 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 • 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? 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 / /								
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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.

**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.