OXFORD HEALTH PLANS®

A UnitedHealthcare Company

NY Member Enrollment & Physician Selection Form
Oxford Health Insurance, Inc.

Mailing Address: P.O. Box 7085, Bridgeport, CT 06601 • 1-800-444-6222 **Corporate Address**: 48 Monroe Turnpike, Trumbull CT 06611 • ***www.oxfordhealth.com***

Thank you for choosing Oxford Health Insurance, Inc., (Oxford) as the health plan for you and your family.

IMPORTANT!

Please print and press down firmly when completing this form. In order to process the attached Member Enrollment Form and begin coverage, all the following information must be completed accurately and in its entirety:

- Date of Employment
- Date of Marriage, if applicable
- Date of Birth
- Social Security Numbers
- Primary Care Physician selections
- Other coverage you or your spouse may have
- Employer and Employee signatures are required at the bottom of form.
- Complete the “Family Health Statement” when instructed by your Benefits Administrator.
- If a dependent is a full-time college student at an accredited school, you must attach proof of full-time student status, such as a paid bill/tuition statement, an Oxford Student Verification Form, or a letter from the registration/bursar’s office confirming enrollment.
- Attach disability paperwork for dependents, if applicable

If you have any questions, please feel free to call our Customer Service Department at 1-800-444-6222.

Thank you again for choosing Oxford.

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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 / /	IS THIS INDIVIDUAL ENROLLING UNDER COBRA? ❑ YES ❑ NO	IF YES, QUALIFYING EVENT / DATE OF QUALIFYING EVENT / /	IS THIS MEMBER DISABLED? ❑ YES ❑ NO
PRODUCT SELECTED: ❑ HMO ❑ FREEDOM ❑ LIBERTY ❑ LIBERTY HMO ❑ OTHER:	IS EMPLOYEE CURRENTLY: ACTIVELY AT WORK? ❑ YES ❑ NO	ON LEAVE OF ABSENCE? ❑ YES ❑ NO	RETIRED? ❑ YES ❑ NO
AVERAGE NUMBER OF HOURS WORKED PER WEEK	DATE OF FULL-TIME EMPLOYMENT / /	EMPLOYEE OCCUPATION	UNION/NON-UNION
EMPLOYER SIGNATURE X		DATE / /	

TO BE COMPLETED BY EMPLOYEE

EMPLOYEE LAST NAME	FIRST NAME & MI	❑ MALE ❑ FEMALE	DATE OF BIRTH / /
STREET ADDRESS	APT. NUMBER	HOME PHONE ( )	BUSINESS PHONE ( )
CITY	STATE ZIP	COUNTY	**SOCIAL SECURITY NUMBER**
OXFORD PRIMARY CARE PHYSICIAN		**OXFORD CODE**	IS THIS A NEW PHYSICIAN FOR YOU? ❑ YES ❑ NO
OXFORD OB/GYN PROVIDER (FEMALE MEMBERS)		**OXFORD OB/GYN CODE**	IS THIS A NEW PHYSICIAN FOR YOU? ❑ YES ❑ NO
TYPE OF COVERAGE: ❑ SINGLE ❑ FAMILY ❑ PARENT / CHILD ❑ HUSBAND / WIFE	ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD? ❑ YES ❑ NO IF YES, CARRIER NAME:	**SOCIAL SECURITY NUMBER OF POLICY HOLDER**	COVERAGE DATES / / TO / /
LANGUAGE: ❑ ENGLISH ❑ SPANISH ❑ CHINESE ❑ OTHER:	COMMUNICATION PREFERENCE (PLEASE RANK IN ORDER FROM 1-4) __MAIL __FAX __ PHONE __ E-MAIL - ADDRESS:		PREFERRED TIME/ PLACE OF CONTACT ❑ DAY ❑ EVENING ❑ HOME ❑ OFFICE

EMPLOYEE'S DEPENDENT INFORMATION

SPOUSE'S LAST NAME	FIRST NAME & MI	DATE OF BIRTH / /	**SOCIAL SECURITY NUMBER**	❑ MALE ❑ FEMALE DATE OF MARRIAGE: / /
IS THIS DEPENDENT DISABLED? ❑ YES ❑ NO	ANY OTHER HEALTH COVERAGE ❑ YES ❑ NO IF YES, NAME:		**SOCIAL SECURITY NUMBER OF POLICY HOLDER**	COVERAGE DATES / / TO / /
SPOUSE'S EMPLOYER	SPOUSE'S OCCUPATION			DAYTIME PHONE ( )
OXFORD PRIMARY CARE PHYSICIAN			**OXFORD CODE**	IS THIS A NEW PHYSICIAN FOR YOU? ❑ YES ❑ NO
OXFORD OB/GYN PROVIDER (FEMALE MEMBERS)			**OXFORD OB/GYN CODE**	IS THIS A NEW PHYSICIAN FOR YOU? ❑ YES ❑ NO
ELIGIBLE CHILD'S LAST NAME	FIRST NAME & MI	DATE OF BIRTH / /	**SOCIAL SECURITY NUMBER**	❑ MALE ❑ FEMALE AGE:
IS THIS DEPENDENT DISABLED? ❑ YES ❑ NO	ANY OTHER HEALTH COVERAGE ❑ YES ❑ NO IF YES, NAME:		**SOCIAL SECURITY NUMBER OF POLICY HOLDER**	COVERAGE DATES / / TO / /
OXFORD PRIMARY CARE PHYSICIAN			**OXFORD CODE**	IS THIS A NEW PHYSICIAN FOR YOU? ❑ YES ❑ NO
OXFORD OB/GYN PROVIDER (FEMALE MEMBERS)			**OXFORD OB/GYN CODE**	IS THIS A NEW PHYSICIAN FOR YOU? ❑ YES ❑ NO
ELIGIBLE CHILD'S LAST NAME	FIRST NAME & MI	DATE OF BIRTH / /	**SOCIAL SECURITY NUMBER**	❑ MALE ❑ FEMALE AGE:
IS THIS DEPENDENT DISABLED? ❑ YES ❑ NO	ANY OTHER HEALTH COVERAGE ❑ YES ❑ NO IF YES, NAME:		**SOCIAL SECURITY NUMBER OF POLICY HOLDER**	COVERAGE DATES / / TO / /
OXFORD PRIMARY CARE PHYSICIAN			**OXFORD CODE**	IS THIS A NEW PHYSICIAN FOR YOU? ❑ YES ❑ NO
OXFORD OB/GYN PROVIDER (FEMALE MEMBERS)			**OXFORD OB/GYN CODE**	IS THIS A NEW PHYSICIAN FOR YOU? ❑ YES ❑ NO
ELIGIBLE CHILD'S LAST NAME	FIRST NAME & MI	DATE OF BIRTH / /	**SOCIAL SECURITY NUMBER**	❑ MALE ❑ FEMALE AGE:
IS THIS DEPENDENT DISABLED? ❑ YES ❑ NO	ANY OTHER HEALTH COVERAGE ❑ YES ❑ NO IF YES, NAME:		**SOCIAL SECURITY NUMBER OF POLICY HOLDER**	COVERAGE DATES / / TO / /
OXFORD PRIMARY CARE PHYSICIAN			**OXFORD CODE**	IS THIS A NEW PHYSICIAN FOR YOU? ❑ YES ❑ NO
OXFORD OB/GYN PROVIDER (FEMALE MEMBERS)			**OXFORD OB/GYN CODE**	IS THIS A NEW PHYSICIAN FOR YOU? ❑ YES ❑ NO

RACE/ETHNICITY (OPTIONAL)

(THIS INFORMATION IS FOR THE PURPOSE OF DATA COLLECTION AND WILL NOT BE USED FOR DETERMINING ELIGIBILITY, RATING OR CLAIM PAYMENT.)

EMPLOYEE:	❑ WHITE ❑ AFRICAN AMERICAN/BLACK ❑ HISPANIC/LATINO ❑ ASIAN ❑ OTHER:	SPOUSE:	❑ WHITE ❑ AFRICAN AMERICAN/BLACK ❑ HISPANIC/LATINO ❑ ASIAN ❑ OTHER:
CHILD:	❑ WHITE ❑ AFRICAN AMERICAN/BLACK ❑ HISPANIC/LATINO ❑ ASIAN ❑ OTHER:	CHILD::	❑ WHITE ❑ AFRICAN AMERICAN/BLACK ❑ HISPANIC/LATINO ❑ ASIAN ❑ OTHER:
CHILD:	❑ WHITE ❑ AFRICAN AMERICAN/BLACK ❑ HISPANIC/LATINO ❑ ASIAN ❑ OTHER:		

**IN ORDER TO HELP US QUICKLY PROCESS THIS FORM AND AVOID DELAYS, PLEASE MAKE SURE ALL AREAS ARE PROPERLY FILLED OUT.
IF YOU HAVE ADDITIONAL DEPENDENTS, PLEASE USE ANOTHER ENROLLMENT FORM TO PROVIDE THE NECESSARY INFORMATION.**

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