UnitedHealthcare®
OXFORD®

Please do not write in this area, for Insurer use only.

Employer Group Information- To be completed by employer

Group name	Group number	(CSP)	Billing group

New Jersey Large Employer - Member Enrollment/Change Request Form - OHI

Oxford Health Insurance, Inc.

Mailing Address: P.O. Box 7085, Bridgeport, CT 06601-7085 • 1-800-444-6222 • www.oxfordhealth.com

A. Type of Activity - To Be Completed By EMPLOYER Refer to instructions before completing this form. (Please Print Clearly)

1). Enrollment	2). Change-*Check all that apply*	Date of Event	Reason	3). Remove or Terminate-*Check all that apply*	Eff. Date	Reason
❑ New employee	❑ Add spouse	/ /				
Effective Date	❑ Add dependent child	/ /		❑ Remove spouse*	/ /	
	❑ Name change	/ /		❑ Remove dependent child*	/ /	
Date of Hire	❑ Change plan	/ /		❑ Employee withdrawal/termination		
	❑ Other	/ /		NOTE: Employee must be enrolled for spouse/ dependent(s) to have coverage. *Please complete Add/Change/Remove and name columns in Section D.		
	❑ Add/Change office ID numbers (PCP or OB/GYN)					

4). Continuation of coverage. i.e., COBRA, State, Total Disability (Not all options are available or applicable. Contact employer for available options)

Coverage for: ❑ Employee ❑ Dependent ❑ Spouse

Length of Continuation: ❑ 12 mos ❑18 mos ❑ 29 mos ❑ 36 mos

❑ Total Disability* *Attach proof of total disability

Date of Loss of Coverage: _____

Date of Qualifying Event: _____

B. Employee Information - Complete Sections B-G (Please Print Clearly)

Social Security No.	Last Name, First Name, M.I.		Home Telephone
Home Address	Apt No.	City, State	Zip Code
Employer Name	Date of Employment	Hours Worked per Week	Work Telephone
Work Address		City, State	Zip Code

C. Plan Option

Your selection must be offered by your employer

1. Indicate plan selected

_____

2. Type of Contract:

❑ Single ❑ Adult & Child(ren)
❑ Family ❑ Husband/Wife

D. Individuals Covered - List individuals for whom you are adding/changing/removing coverage. Attach sheet to list additional children (attach proof if full-time college student).

	(A)dd (C)hange (R)emove	Last Name, First Name, M.I.	Sex M F	Birthdate MM DD YY	Social Security Number	Other Health Coverage	PCP ID #	Other Rx Drug Coverage	Current Patient?	OB/GYN ID #	Current Patient?
Employee						**If Other Medical Coverage Has Been Entered It Will Appear on the Following Page(s)**		**If Other Medical Coverage Has Been Entered It Will Appear on the Following Page(s)**	❑ Yes		❑ Yes
Spouse									❑ Yes		❑ Yes
Child									❑ Yes		❑ Yes
Child									❑ Yes		❑ Yes
Child									❑ Yes		❑ Yes

E. Other /Previous Insurance

Is your spouse employed? ❑ Yes ❑ No

If "yes", give name and address of your spouse's employer:

_____

If "yes" to Other Health coverage (Section D), give name and policy number of insurance carrier, HMO, or other source

If Other Medical / Medicare Coverage Has Been Entered It Will Appear on the Following Page(s)

If "Yes" to Other Rx Drug Coverage (Section D), give name and policy number of insurance carrier, HMO, or other source.

F. Dependent Information

Does any dependent listed in Section D live at a different address than the employee? ❑ Yes ❑ No

If "yes", who and what address?_____

_____

Explain the circumstances:_____

_____

If any dependent's last name differs from yours,

explain the circumstances:_____

_____

_____

G. Employee Signature

I represent that all the information supplied in this application is true and complete. I hereby agree to the conditions of enrollment of this application. I authorize deductions from my earnings for any required contributions.

Employee Signature – Required

X _____

Date

E-mail Address _____

If you have any questions concerning the benefits and services provided by or excluded under this agreement, contact a Customer Services representative at 1-800-444-6222 before signing this form.

H. Employer Verification - To be completed by EMPLOYER

Employer Signature – Required	Title	Date
X		

Employee copy may be used as a temporary ID card for 30 days from the effective date if authorized by the employer. Coverage must be verified with Oxford Health Plans prior to visiting a specialist or admission to a hospital.

Employee Name: ______________________________ SSN: ________________________________

	(A)dd (C)hange (R)emove	Name	Sex		Birth Date	Social Security Number	Other Health Coverage	PCP ID#	Other Rx Drug Coverage	Current Patient?	OB/GYN ID#	Current Patient?
			M	F								
Child							**If Other Medical Coverage Has Been Entered It Will Appear on the Following Page(s)**		**If Other Medical Coverage Has Been Entered It Will Appear on the Following Page(s)**	☐ Yes		☐ Yes
Child										☐ Yes		☐ Yes
Child										☐ Yes		☐ Yes
Child										☐ Yes		☐ Yes
Child										☐ Yes		☐ Yes
Child										☐ Yes		☐ Yes
Child										☐ Yes		☐ Yes
Child										☐ Yes		☐ Yes
Child										☐ Yes		☐ Yes
Child										☐ Yes		☐ Yes
Child										☐ Yes		☐ Yes

Employee Name: ______________________________ SSN: ________________________________

Child							**If Other Medical Coverage Has Been Entered It Will Appear on the Following Page(s)**		**If Other Medical Coverage Has Been Entered It Will Appear on the Following Page(s)**	☐ Yes		☐ Yes
Child										☐ Yes		☐ Yes
Child										☐ Yes		☐ Yes
Child										☐ Yes		☐ Yes
Child										☐ Yes		☐ Yes
Child										☐ Yes		☐ Yes
Child										☐ Yes		☐ Yes
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Child										☐ Yes		☐ Yes
Child										☐ Yes		☐ Yes