OXFORD HEALTH PLANS®

A UnitedHealthcare Company

New Jersey Small Member Enrollment/Change Request Form - OHI

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

Instructions

Employer

- Complete the Employer Group Information in the upper right corner of the form.

Section A - Type of Activity: Check box(es) indicating reason(s) for submitting application.

- Complete **Section I Employer Verification** at the bottom of the form.

  Employer must complete this section for all new enrollments, coverage changes and terminations.
  Employer must sign and date the Enrollment/Change Request Form in order for it to be processed.

Employee - Complete Sections B-H

Section B - Employee Information:

- Complete all information in order for your application to be processed.

Section C - Plan Option:

- Indicate Plan Option selected and the type of contract.
- Select only an option offered by your employer.

Section D - Individuals Covered:

- Add/Change/Remove - Use "A", "C", or "R" to indicate whether you are adding, changing or removing coverage for an individual.
- Print your full name along with the name(s) of your dependent(s), if applicable. Indicate Sex, Birthdate, and Social Security Number for each individual listed.
- 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.
- If you or your dependent(s) have other health coverage, check off the "Yes" box(es) and complete Section F - Other/Previous Insurance.
- From the appropriate provider roster, locate the office ID number for the primary care physician, ob/gyn (if applicable) and/or dentist (if applicable). Indicate provider ID number selection(s) on the form.
- If you are a current patient, please check the "Current Patient" box.

Section E - Pre-Existing Conditions Statement:

- Complete this section for all new enrollments. **Exceptions:** For Small Employer Group coverage, this section must be completed only by persons enrolling in group coverage in a group of 2-5 employees and by late entrants.

Section F - Other/Previous Insurance:

- Complete this section for all new enrollments or coverage changes. Coverage includes group coverage, governmental coverage, a church plan or Medicare.

Section G - Dependent Information:

- Complete this section for all new enrollments or coverage changes.

Section H - Employee Signature:

- Complete this section for all new enrollments, coverage changes and terminations.
- Employee must sign and date the Enrollment/Change Request Form in order for it to be processed.

Section I - Employer Verification:

- Employer must complete this section for all new enrollments, coverage changes and terminations.
- Employer must sign and date the Enrollment/Change Request Form in order for it to be processed.

Conditions of Enrollment Applicant Acknowledgments and Agreements

On behalf of myself and the dependents listed on the form, I agree to or with the following:

1. **(a)** I authorize the sources stated below to give to Oxford Health Insurance, Inc. ("OHI"), or any consumer reporting agency acting on its behalf, information about me or my minor children, if applying for coverage. Such information will pertain to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition. Authorized sources are any physician or medical professional; any hospital, clinic or other medical care institution; any carrier; any consumer reporting agency; any employer.

   (b) I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action, which OHI has taken in reliance on the authorization. I understand this authorization will not be valid after 30 months, if not revoked earlier.

   (c) I know that I have a right to receive a copy of the authorization if I request one.

   (d) I agree that a photocopy of this authorization is as valid as the original.
2. I acknowledge by enrolling in an OHI plan that coverage is provided by OHI in accordance with the contract.
3. Enrollment of myself and of the listed dependent(s) into the plan is effective on acceptance by OHI.
4. Coverage and benefits are contingent on timely payment of premiums and may be terminated as provided in the plan documents. My employer is hereby authorized to withhold payments from my wages, as appropriate.

Misrepresentation

5. Any person who includes any false or misleading information on an Enrollment/Change Request Form for a health benefits plan is subject to criminal and civil penalties.

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

Employer Group Information- To be completed by employer

Group name	Group number	(CSP)	Billing group

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

1). Enrollment

❑ New employee

Effective Date

Date of Hire

2). Change-*Check all that apply*

	Date of Event	Reason
❑ Add spouse	/ /	
❑ Add dependent child	/ /	
❑ Name change	/ /	
❑ Change plan	/ /	
❑ Other	/ /	
❑ Add/Change PCP or OB/GYN Eff. Date:	/ /	

3). Remove or Terminate-*Check all that apply*

	Eff. Date	Reason
❑ Remove spouse	/ /	
❑ Remove dependent child	/ /	
❑ Employee withdrawal/termination		

NOTE: Employee must be enrolled for spouse/ dependent(s) to have coverage. *Please complete Add/Change/Remove and Name columns in Section D.

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(s)

Length of Continuation: ❑ 12mos ❑ 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-H (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 student).

	(A)dd (C)hange (R)emove	Last Name, First Name, M.I.	Sex M	Sex F	Birthdate MM DD YY	Social Security Number	Other Health Coverage	PCP ID #	Current Patient?	OB/GYN ID #	Current Patient?	Previous Coverage
Employee					/ /		❑ Yes		❑ Yes		❑ Yes	❑ Yes
Spouse					/ /		❑ Yes		❑ Yes		❑ Yes	❑ Yes
Child					/ /		❑ Yes		❑ Yes		❑ Yes	❑ Yes
Child					/ /		❑ Yes		❑ Yes		❑ Yes	❑ Yes
Child					/ /		❑ Yes		❑ Yes		❑ Yes	❑ Yes

E. Pre-Existing Conditions Statement

Note: This information may only be used to determine if a condition is a pre-existing condition. You CANNOT be denied coverage under a health benefits plan on the basis of accurate responses to the following questions. Carriers can only use the information to expedite the processing of claims.

❑ Yes ❑ No

1. During the past 6 months, have you or any dependent to be covered had or been diagnosed as having any of the following? If "yes", check appropriate boxes below:

- ❑ a. Alcoholism or drug abuse
- ❑ b. Arthritis
- ❑ c. Blood disorder
- ❑ d. Back or neck disorder, injury or pain
- ❑ e. Cancer or tumors
- ❑ f. Diabetes
- ❑ g. Gastro or intestinal disorder
- ❑ h. Heart disorder/condition or chest pain
- ❑ i. High blood pressure
- ❑ j. Kidney or liver disorder
- ❑ k. Lung or respiratory disorder
- ❑ l. Mental or nervous disorder
- ❑ m. Paralysis, stroke or epilepsy

Yes	No	2. During the past 6 months, have you or any dependent to be covered:
❑	❑	a. been examined or treated by a physician or other healthcare provider for any condition, illness, or injury, other than as stated above?
❑	❑	b. been advised to have treatment or surgery or testing that has not yet been done?
❑	❑	c. been admitted to a hospital or other healthcare facility as an inpatient?
❑	❑	d. prescribed medications?

Please give details for "yes" answers to any part of Questions 1 or 2 on a separate sheet of paper. This separate sheet should be signed and dated.

F. 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 or HMO, or other source. If enrolled in Medicare Parts A and/or B, identify the coverage and provide the Medicare ID#:

_____

_____

_____

If "yes" to previous coverage, identify names of persons, give effective date and date coverage terminated, name of previous carrier and plan number:

_____

_____

_____

G. Dependent Information

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

If "yes", who and at what address?

Explain the circumstances:

If any dependent's last name differs from yours, explain the circumstances.

H. Employee Signature

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

I represent that all the information supplied in this Enrollment/Change Request Form is true and complete. I hereby agree to the conditions of the employee copy of this Enrollment/Change Request Form. I authorize deductions from my earnings for any required contributions.

Employee Signature – Required

X _____ Date _____

E-mail Address _____

I. 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.