New York Member Enrollment Form – OHI

MAILING ADDRESS: P. O. Box 7085, Bridgeport CT 06601 • 1-800-444-6222 • *www.oxfordhealth.com*

UnitedHealthcare®
OXFORD®

THANK YOU FOR CHOOSING AN OXFORD PRODUCT FOR YOU AND YOUR FAMILY.

IMPORTANT:

PLEASE PRINT AND PRESS DOWN FIRMLY WHEN COMPLETING THIS FORM.

IN ORDER TO PROCESS THE ATTACHED FORM AND BEGIN COVERAGE, ALL FIELDS MUST BE COMPLETED ACCURATELY AND IN ITS ENTIRETY.

BE SURE TO:

- Use only blue or black ballpoint pen
- Enter all dates using the MM/DD/YYYY format
- Employer and employee signatures are required
- List any coordinating coverage (coverage in addition to this coverage)
- List any coverage you had prior to this coverage
- Attach disability paperwork, if applicable
- Check “full-time student” in the child column if the child is between the ages of 19-23 and a full-time student at an accredited institution
- Submit this form within 31 days of the requested effective date or within 60 days of the qualifying event for COBRA or State Continuation

IF YOU HAVE ANY QUESTIONS, PLEASE FEEL FREE TO CALL CUSTOMER SERVICE AT

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A. Group Information (To be completed by the **employer**) — **Please print neatly using black or blue ballpoint pen • ALL DATES MUST BE: MM/DD/YYYY**

Group Number / Group Name	Plan CSP / Billing Group	Date of Hire	Effective Date	Occupation
		/ /	/ /	
☐ On Leave of Absence ☐ Union Employee ☐ Retired ☐ Disabled	COBRA/SC Qualifying Event	Event Date / /	**Employer Signature** X	Date / /

B. Applicant Details (To be completed by the **employee**)	**Employee/Subscriber**	**Spouse**	**Child**	**Child**
Social Security Number:				
Last Name:				
First Name, Middle Initial:				
Date of Birth: (MM/DD/YYYY)	/ /	/ /	/ /	/ /
Gender and Disability Status: (Check appropriate boxes.)	☐ M ☐ F / ☐ Disabled	☐ M ☐ F / ☐ Disabled	☐ M ☐ F / ☐ Disabled	☐ M ☐ F / ☐ Disabled
Primary Care Physician (PCP) ID Number: PCP Name: (If an existing patient of PCP, check "Yes".)	☐ Yes	☐ Yes	☐ Yes	☐ Yes
Check all that apply:		☐ Domestic Partner	☐ Full-time Student	☐ Full-time Student
Prior Carrier (List coverage prior to this.) ☐ Same for all — Carrier: / Policy Number: / From Date / Thru date::	/ / / /	/ / / /	/ / / /	/ / / /

C. Coordination of Benefits	**Employee/Subscriber**	**Spouse**	**Child**	**Child**
Medicare Coverage — Check appropriate box and list effective date:	☐ Part A / / ☐ Part B / / ☐ Part D / /	☐ Part A / / ☐ Part B / / ☐ Part D / /	☐ Part A / / ☐ Part B / / ☐ Part D / /	☐ Part A / / ☐ Part B / / ☐ Part D / /
Pharmacy ☐ Same for all **Effective Date**: / / — Policy Number: / Carrier: / Policy Holder: / Group Number:	BIN: PCN:	BIN: PCN:	BIN: PCN:	BIN: PCN:
Medical ☐ Same for all — Policy Number: / Carrier: / Policy Holder: / Effective Date:	/ /	/ /	/ /	/ /

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. I authorize any health provider or insurer to furnish Oxford any records concerning me or any enrolled member of my family for whom information is requested.

Employee's Address (Apt #) / City / State / Zip	**Employee's Signature** X	Date / /