

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

## New Jersey Small Member Enrollment/Change Request Form - OHP

Oxford Health Plans (NJ), Inc.

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

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)

<b>1). Enrollment</b> <input type="checkbox"/> New employee		<b>2). Change-Check all that apply</b>		<b>Date of Event</b> / /	<b>Reason</b>	<b>3). Remove or Terminate-Check all that apply</b>		<b>Eff. Date</b> / /	<b>Reason</b>	<b>4). Continuation of coverage. i.e., COBRA, State, Total Disability</b> (Not all options are available or applicable. Contact employer for available options) <b>Coverage for:</b> <input type="checkbox"/> Employee <input type="checkbox"/> Dependent(s) <b>Length of continuation:</b> <input type="checkbox"/> 12 mos <input type="checkbox"/> 18 mos <input type="checkbox"/> 29 mos <input type="checkbox"/> 36 mos <input type="checkbox"/> Total Disability* *Attach proof of total disability <b>Date of Loss of Coverage:</b> ____/____/____ <b>Date of Qualifying Event:</b> ____/____/____
<b>Effective Date</b>	<input type="checkbox"/> Add spouse		/ /		<input type="checkbox"/> Remove spouse		/ /			
	<input type="checkbox"/> Add dependent child		/ /		<input type="checkbox"/> Remove dependent child		/ /			
<b>Date of Hire</b>	<input type="checkbox"/> Name change		/ /		<input type="checkbox"/> Employee withdrawal/termination					
	<input type="checkbox"/> Change plan		/ /		NOTE: Employee must be enrolled for spouse/dependent(s) to have coverage. *Please complete Add/Change/Remove and Name columns in Section D.					
	<input type="checkbox"/> Other		/ /							
	<input type="checkbox"/> Add/Change PCP or OB/GYN		Eff. Date: / /							

### 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

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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).

	(Add/Change/Remove)	Last Name, First Name, M.I.	Sex		Birthdate MM DD YY	Social Security Number	Other Health Coverage	PCP ID #	Current Patient?	OB/GYN ID #	Current Patient?	Previous Coverage
			M	F								
Employee					/ /		<input type="checkbox"/> Yes		<input type="checkbox"/> Yes		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Spouse					/ /		<input type="checkbox"/> Yes		<input type="checkbox"/> Yes		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Child					/ /		<input type="checkbox"/> Yes		<input type="checkbox"/> Yes		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Child					/ /		<input type="checkbox"/> Yes		<input type="checkbox"/> Yes		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Child					/ /		<input type="checkbox"/> Yes		<input type="checkbox"/> Yes		<input type="checkbox"/> Yes	<input type="checkbox"/> 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.

<input type="checkbox"/> Yes <input type="checkbox"/> 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:	Yes No	2. During the past 6 months, have you or any dependent to be covered:
	<input type="checkbox"/> a. Alcoholism or drug abuse <input type="checkbox"/> b. Arthritis <input type="checkbox"/> c. Blood disorder <input type="checkbox"/> d. Back or neck disorder, injury or pain <input type="checkbox"/> e. Cancer or tumors <input type="checkbox"/> f. Diabetes <input type="checkbox"/> g. Gastro or intestinal disorder	<input type="checkbox"/> h. Heart disorder/condition or chest pain <input type="checkbox"/> i. High blood pressure <input type="checkbox"/> j. Kidney or liver disorder <input type="checkbox"/> k. Lung or respiratory disorder <input type="checkbox"/> l. Mental or nervous disorder <input type="checkbox"/> m. Paralysis, stroke or epilepsy	<input type="checkbox"/> a. been examined or treated by a physician or other healthcare provider for any condition, illness, or injury, other than as stated above? <input type="checkbox"/> b. been advised to have treatment or surgery or testing that has not yet been done? <input type="checkbox"/> c. been admitted to a hospital or other healthcare facility as an inpatient? <input type="checkbox"/> 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****G. Dependent Information**

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 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:

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 contract, 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 enrollment on the employee copy of the 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 employer. Coverage must be verified with Oxford Health Plans prior to visiting a specialist or admission to a hospital.