Oxford Health Plans®

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

New Jersey Small 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 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

2. During the past 6 months, have you or any dependent to be covered:

Yes	No	
❑	❑	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.

WHITE COPY: OXFORD **PINK COPY: EMPLOYER** **YELLOW COPY: MEMBER**