

**Member Enrollment Form** 

EMPLOYEE/APPLICANT SIGNATURE

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

DATE

Mailing Address: P.0	O. Box 7085,	Bridg	eport, (	CT 066	601 • 2	203-8	}52-1 <i>4</i>	142 •8	800-44	4-622.	2															
To Be Completed By EMPLOYER																					(	Plea	se Pr	int)		
NAME OF GROUP (EMPLOYER)							GROUP NUMBER						CONTRACT SPECIFIC PACKAGE (CSP)							BILLING GROUP (BG)						
EMPLOYEE'S EFFECTIVE DATE OF COVERAGE IS INDIVIDUAL COVERED UNDER COBRA?  MO. DAY YEAR □ YES □ NO								? IFYÉS, QUALIFYING EVENT											DATE OF QUALIFYING EVENT MO. DAY YEAR							
						/EE OCCUPATION: ☐ EXECUTIVE ☐ MANAGEMENT ☐ NON-MANAGEM RLY ☐ OTHER (PLEASE SPECIFY)										ME	ENT EMPLOYEE CLASSIFICATION UNION NON-UNION									
X EMPLOYER SIGNATURE																			DATE							
To Be Completed By EMPLOYEE													(Please Print)													
SOCIAL SECURITY NO.	LAST NAME																					100	JU 1 .			
FIRST NAME	+++	+	++	+	MI E	BIRTH I	DATE						MALE	HOME PI	HONE				BL	JSINES	SS PHO	NE				
		$\perp$		$\perp$		MO.		DAY		YEAR		☐ FEMALE ( )							( ) STATE ZIP							
STREET ADDRESS					APT. NO. CITY								211													
WILLYOU HAVE ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED W  YES  NO IFYES, CARRIER NAME							TH OXFORD? NAME OF POLICY HOLDER													POLIC	Y STA	RT DATE				
OXFORD CODE OF PRIMARY CARE PHYSICIAN S	OXFORD CODE OF PRIMARY CARE PHYSICIAN SELECTED					$\Box$		DU AN E	AN EXISTING PATIENT?				PRIOR HEALTH INSURANCE INFORMATION:								-					
OXFORD CODE OF OB/GYN SELECTED (Female Members)	+		+	++	十	AREYOU AN EXISTING PATIENT?  YES NO						rier na Erage e	me Begin dat	1	COVE	COVERAGE END DATE				1						
EMPLOYEE'S Dependent Informa	e only	complet	e for d	lepende	ents w						rd pol	l <u>i</u> cy					(	Plea	Please Print)							
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SPOUSE'S BIRTH DATE	☐ MALE		TE OF MAI		<u> </u>				SPOU:	SE'S EM	 //PLOYE	R												—		
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☐ YES ☐ NO IFYES, CARRIER NAME							1 1																			
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OXFORD CODE OF OB/GYN SELECTED (Female Members)	+		+	++	$\top$	AREYOU AN EXISTING PATIENT?  YES INO  CARRIER NAME  COVERAGE BEGIN DATE / /								1		COVE	RAGE	END D	ATE	/	/					
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A I understand that my enrethose described in the applicable Ox understand that, in order to qualify fent to dents must choose an Oxford affiliat referral from that physician to an Ox specialist care. I authorize any health Plans (NY), Inc. any records concern for whom information is requested. shall be valid as the original.	rollment and kford Health for HMO ben ted physiciar kford-affiliate h provider or ning me or ar	I bene Plans nefits, n for p ed spe or insur ny enr	efits are s (NY), I , I and a primary ecialist prer to fure to fure folled n	e in ac Inc. H any er y care physi- urnish memb	ccordan IMO Ce nrolled and se ician fo h Oxfor ber of n	nce wertificated dependent of the depend	with cate. I en- e a ealth amily	HN the un mi Ox ph be	B MO Cere e applindersta ust see kford-a nysiciar enefits,	I un rtificat cable and tha ek care affiliate n. I fur I will	ndersi te, my Oxfor at, in e thro ed sper ther u	tand y enrord Ho orde ough ecial unde igible	that i collme ealth er to re our C ist ph erstan e only	n addition and the series of t	on to benef be, In IMO I ffiliate with a I do I	the fits a c. Subene ed prant a can	applione in a ppleone in a pple	icab acc mer I and ry ca rized re to insu	ole Oxfordan ntal Fr d any are ph d refen o these urance	ford I ce w eedd enro ysici ral fr e req e cov	Health with the om Pla olled d ian or om the juirem	h Pla ose c an Ce leper thro ne pr nents und	describertificandents  ugh and	bed in ate. I s n care MO		

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 concerning any fact material thereto commits fraudulent act, which is a crime and subjects such person to criminal and civil penalties.

DATE

EMPLOYEE/APPLICANT SIGNATURE