OXFORD HEALTH PLANS®

A UnitedHealthcare Company

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

New York Member Enrollment Form - OHI

Mailing Address: P.O. Box 7085, Bridgeport, CT 06601 • www.oxfordhealth.com

To Be Completed By EMPLOYER (Please Print)

NAME OF GROUP (EMPLOYER) | GROUP NUMBER | CONTRACT SPECIFIC PACKAGE (CSP) | BILLING GROUP (BG)

EMPLOYEE'S EFFECTIVE DATE OF COVERAGE MO. DAY YEAR | IS INDIVIDUAL COVERED UNDER COBRA? ❑ YES ❑ NO IF YES, QUALIFYING EVENT | DATE OF QUALIFYING EVENT MO. DAY YEAR

DATE OF FULL-TIME EMPLOYMENT MO. DAY YEAR | AVERAGE NO. OF HOURS WORKED PER WEEK | EMPLOYEE OCCUPATION: ❑ EXECUTIVE ❑ MANAGEMENT ❑ NON-MANAGEMENT ❑ HOURLY ❑ OTHER (PLEASE SPECIFY) | EMPLOYEE CLASSIFICATION ❑ UNION ❑ NON-UNION

X EMPLOYER SIGNATURE | DATE

To Be Completed By EMPLOYEE (Please Print)

SOCIAL SECURITY NO. | LAST NAME

FIRST NAME | MI | BIRTH DATE MO. DAY YEAR | ❑ MALE ❑ FEMALE | HOME PHONE ( ) | BUSINESS PHONE ( )

STREET ADDRESS | APT. NO. | CITY | STATE | ZIP

WILL YOU HAVE ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD? ❑ YES ❑ NO IF YES, CARRIER NAME | NAME OF POLICY HOLDER | POLICY START DATE / /

OXFORD CODE OF PRIMARY CARE PHYSICIAN SELECTED | ARE YOU AN EXISTING PATIENT? ❑ YES ❑ NO | PRIOR HEALTH INSURANCE INFORMATION: CARRIER NAME

OXFORD CODE OF OB/GYN SELECTED (Female Members) | ARE YOU AN EXISTING PATIENT? ❑ YES ❑ NO | COVERAGE BEGIN DATE / / COVERAGE END DATE / /

EMPLOYEE'S Dependent Information Please only complete for dependents who will be covered on your Oxford policy (Please Print)

SPOUSE'S SOCIAL SECURITY NUMBER | SPOUSE'S LAST NAME | SPOUSE'S FIRST NAME | MI

SPOUSE'S BIRTH DATE MO. DAY YEAR | ❑ MALE ❑ FEMALE | DATE OF MARRIAGE MO. DAY YEAR | SPOUSE'S EMPLOYER

WILL YOU HAVE ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD? ❑ YES ❑ NO IF YES, CARRIER NAME | NAME OF POLICY HOLDER | POLICY START DATE / /

OXFORD CODE OF PRIMARY CARE PHYSICIAN SELECTED | ARE YOU AN EXISTING PATIENT? ❑ YES ❑ NO | PRIOR HEALTH INSURANCE INFORMATION: CARRIER NAME

OXFORD CODE OF OB/GYN SELECTED (Female Members) | ARE YOU AN EXISTING PATIENT? ❑ YES ❑ NO | COVERAGE BEGIN DATE / / COVERAGE END DATE / /

ELIGIBLE CHILD'S SOCIAL SECURITY NO. | ELIGIBLE CHILD'S LAST NAME | ELIGIBLE CHILD'S FIRST NAME | MI | ❑ MALE ❑ FEMALE

ELIGIBLE CHILD'S BIRTH DATE MO. DAY YEAR | IS THIS DEPENDENT DISABLED? ❑ YES ❑ NO | WILL YOU HAVE ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD? ❑ NO ❑ YES IF YES, CARRIER NAME: | NAME OF POLICY HOLDER | POLICY START DATE / /

OXFORD CODE OF PRIMARY CARE PHYSICIAN SELECTED | ARE YOU AN EXISTING PATIENT? ❑ YES ❑ NO | PRIOR HEALTH INSURANCE INFORMATION: CARRIER NAME

OXFORD CODE OF OB/GYN SELECTED (Female Members) | ARE YOU AN EXISTING PATIENT? ❑ YES ❑ NO | COVERAGE BEGIN DATE / / COVERAGE END DATE / /

ELIGIBLE CHILD'S SOCIAL SECURITY NO. | ELIGIBLE CHILD'S LAST NAME | ELIGIBLE CHILD'S FIRST NAME | MI | ❑ MALE ❑ FEMALE

ELIGIBLE CHILD'S BIRTH DATE MO. DAY YEAR | IS THIS DEPENDENT DISABLED? ❑ YES ❑ NO | WILL YOU HAVE ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD? ❑ NO ❑ YES IF YES, CARRIER NAME: | NAME OF POLICY HOLDER | POLICY START DATE / /

OXFORD CODE OF PRIMARY CARE PHYSICIAN SELECTED | ARE YOU AN EXISTING PATIENT? ❑ YES ❑ NO | PRIOR HEALTH INSURANCE INFORMATION: CARRIER NAME

OXFORD CODE OF OB/GYN SELECTED (Female Members) | ARE YOU AN EXISTING PATIENT? ❑ YES ❑ NO | COVERAGE BEGIN DATE / / COVERAGE END DATE / /

ELIGIBLE CHILD'S SOCIAL SECURITY NO. | ELIGIBLE CHILD'S LAST NAME | ELIGIBLE CHILD'S FIRST NAME | MI | ❑ MALE ❑ FEMALE

ELIGIBLE CHILD'S BIRTH DATE MO. DAY YEAR | IS THIS DEPENDENT DISABLED? ❑ YES ❑ NO | WILL YOU HAVE ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD? ❑ NO ❑ YES IF YES, CARRIER NAME: | NAME OF POLICY HOLDER | POLICY START DATE / /

OXFORD CODE OF PRIMARY CARE PHYSICIAN SELECTED | ARE YOU AN EXISTING PATIENT? ❑ YES ❑ NO | PRIOR HEALTH INSURANCE INFORMATION: CARRIER NAME

OXFORD CODE OF OB/GYN SELECTED (Female Members) | ARE YOU AN EXISTING PATIENT? ❑ YES ❑ NO | COVERAGE BEGIN DATE / / COVERAGE END DATE / /

If you have additional dependents, please use another enrollment form to provide the necessary information.

In order to help us quickly process this form and avoid delays, please make sure all areas are properly filled out.

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.

X EMPLOYEE/APPLICANT SIGNATURE | DATE