OXFORD HEALTH PLANS®

A UnitedHealthcare Company

ADDITION/TERMINATION/CHANGE FORM

Mailing Address: P.O. Box 7085, Bridgeport, CT 06601 • 1-800-444-6222 **Corporate Address**: 48 Monroe Turnpike, Trumbull CT 06611 • ***www.oxfordhealth.com***

FOR YOUR CONVENIENCE, THIS FORM CAN BE COMPLETED ONLINE AT THE EMPLOYER AREA OF OUR WEB SITE.

GENERAL INFORMATION

NAME OF GROUP (EMPLOYER}

GROUP NUMBER

CONTRACT SPECIFIC PACKAGE (CSP)

BILLING GROUP (BG)

EMPLOYER SIGNATURE

DATE

X / /

TO BE COMPLETED BY EMPLOYEE

EMPLOYEE LAST NAME

FIRST NAME & MI

MEMBER ID

MALE
FEMALE

DATE OF BIRTH / /

STREET ADDRESS

APT. NUMBER

HOME PHONE ( )

BUSINESS PHONE ( )

CITY

STATE ZIP

COUNTY

SOCIAL SECURITY NUMBER

LANGUAGE: ❑ ENGLISH ❑ SPANISH ❑ CHINESE ❑ OTHER:

COMMUNICATION PREFERENCE (PLEASE RANK IN ORDER FROM 1-4)
__MAIL __FAX __ PHONE __ E-MAIL - ADDRESS:

PREFERRED TIME/ PLACE OF CONTACT
❑ DAY ❑ EVENING ❑ HOME ❑ OFFICE

EMPLOYEE'S DEPENDENT INFORMATION

❑ ADD SPOUSE TO PLAN EFFECTIVE (DATE) / / REASON FOR ADDITION: ❑ NEWLY MARRIED – DATE OF MARRIAGE / / ❑ OPEN ENROLLMENT ❑ OTHER (PLEASE SPECIFY)

SPOUSE'S LAST NAME | FIRST NAME & MI | DATE OF BIRTH / / | **SOCIAL SECURITY NUMBER** | ❑ MALE ❑ FEMALE | DATE OF MARRIAGE / /

IS THIS DEPENDENT DISABLED? ❑ YES ❑ NO | ANY OTHER HEALTH COVERAGE ❑ YES ❑ NO IF YES, CARRIER NAME: | **SOCIAL SECURITY NUMBER OF POLICY HOLDER** | COVERAGE DATES / / TO / /

SPOUSE'S EMPLOYER | SPOUSE'S OCCUPATION | DAYTIME PHONE ( )

OXFORD PRIMARY CARE PHYSICIAN | **OXFORD CODE** | OXFORD OB/GYN PROVIDER (FEMALE MEMBERS) | **OXFORD OB/GYN CODE** | ARE EITHER OF THESE PHYSICIANS NEW FOR YOU? **PCP** ❑ YES ❑ NO **OB/GYN** ❑ YES ❑ NO

PRIOR HEALTH INSURANCE INFORMATION | CARRIER NAME | COVERAGE BEGIN DATE / / | COVERAGE END DATE / /

❑ ADD DEPENDENT TO PLAN EFFECTIVE (DATE) / / REASON FOR ADDITION: ❑ NEW BORN ❑ OPEN ENROLLMENT ❑ OTHER (PLEASE SPECIFY)

ELIGIBLE CHILD'S LAST NAME | FIRST NAME & MI | DATE OF BIRTH / / | **SOCIAL SECURITY NUMBER** | ❑ MALE ❑ FEMALE

IS THIS DEPENDENT DISABLED? ❑ YES ❑ NO | ANY OTHER HEALTH COVERAGE ❑ YES ❑ NO IF YES, NAME: | **SOCIAL SECURITY NUMBER OF POLICY HOLDER** | COVERAGE DATES / / TO / /

OXFORD PRIMARY CARE PHYSICIAN | **OXFORD CODE** | OXFORD OB/GYN PROVIDER (FEMALE MEMBERS) | **OXFORD OB/GYN CODE** | ARE EITHER OF THESE PHYSICIANS NEW FOR YOU? **PCP** ❑ YES ❑ NO **OB/GYN** ❑ YES ❑

PRIOR HEALTH INSURANCE INFORMATION | CARRIER NAME | COVERAGE BEGIN DATE / / | COVERAGE END DATE / /

❑ TERMINATE THE FOLLOWING INDIVIDUALS: ❑ EMPLOYEE ❑ SPOUSE ONLY ❑ DEPENDENT(S) ONLY ❑ SPOUSE AND DEPENDENT(S) ONLY ❑ FAMILY

LAST DATE OF COVERAGE / / REASON FOR TERMINATION ❑ LEFT EMPLOYER ❑ SWITCHED TO ANOTHER PLAN ❑ DISCONTINUE COBRA ❑ OTHER (PLEASE SPECIFY)

❑ CHANGE EFFECTIVE DATE / /

LAST NAME | FIRST NAME & MI | DATE OF BIRTH / / | **SOCIAL SECURITY NUMBER** | ❑ MALE ❑ FEMALE

IS THIS DEPENDENT DISABLED? ❑ YES ❑ NO | ANY OTHER HEALTH COVERAGE ❑ YES ❑ NO IF YES, NAME: | **SOCIAL SECURITY NUMBER OF POLICY HOLDER** | COVERAGE DATES / / TO / /

OXFORD PRIMARY CARE PHYSICIAN | **OXFORD CODE** | OXFORD OB/GYN PROVIDER (FEMALE MEMBERS) | **OXFORD OB/GYN CODE** | ARE EITHER OF THESE PHYSICIANS NEW FOR YOU? **PCP** ❑ YES ❑ NO **OB/GYN** ❑ YES ❑ NO

PRIOR HEALTH INSURANCE INFORMATION | CARRIER NAME | COVERAGE BEGIN DATE | COVERAGE END DATE

❑ CHANGE TO COBRA ❑ EMPLOYEE ❑ EMPLOYEE AND SPOUSE ❑ EMPLOYEE AND DEPENDENT(S) ❑ SPOUSE ONLY ❑ DEPENDENT(S) ONLY ❑ SPOUSE AND DEPENDENT(S) ONLY ❑ FAMILY
(STATE SPECIFIC MEMBER ENROLLMENT FORM NEEDS TO BE FILLED OUT FOR ABOVE)

QUALIFYING EVENT (REASON FOR COBRA) | DATE OF QUALIFYING EVENT / / COBRA EFFECTIVE DATE / /
(IMPORTANT NOTE: THIS FORM IS FOR USE ONLY BY GROUPS IN WHICH OXFORD HEALTH PLANS IS NOT ADMINISTERING COBRA)

❑ TRANSFER MEMBER': ❑ CONTRACT SPECIFIC PACKAGE (CSP) ❑ BILLING GROUP (BG) ❑ OTHER | EFFECTIVE DATE:

REASON: | FROM: / / TO: / /

RETIREE DRUG SUBSIDY MEMBER (IF APPLICABLE) ❑ YES ❑ NO ACTIVELY WORKING MEMBER? ❑ YES ❑ NO MEMBER ENROLLED IN: ❑ MEDICARE PART A ❑ MEDICARE B ❑ MEDICARE PART D (CHECK ALL THAT APPLY)

RACE/ETHNICITY (OPTIONAL)

(THIS INFORMATION IS FOR THE PURPOSE OF DATA COLLECTION AND WILL NOT BE USED FOR DETERMINING ELIGIBILITY, RATING OR CLAIM PAYMENT.)

EMPLOYEE: ❑ WHITE ❑ AFRICAN AMERICAN/BLACK ❑ HISPANIC/LATINO ❑ ASIAN ❑ OTHER:
CHILD: ❑ WHITE ❑ AFRICAN AMERICAN/BLACK ❑ HISPANIC/LATINO ❑ ASIAN ❑ OTHER:
CHILD: ❑ WHITE ❑ AFRICAN AMERICAN/BLACK ❑ HISPANIC/LATINO ❑ ASIAN ❑ OTHER:

SPOUSE: ❑ WHITE ❑ AFRICAN AMERICAN/BLACK ❑ HISPANIC/LATINO ❑ ASIAN ❑ OTHER:
CHILD: ❑ WHITE ❑ AFRICAN AMERICAN/BLACK ❑ HISPANIC/LATINO ❑ ASIAN ❑ OTHER:

IN ORDER TO HELP US QUICKLY PROCESS THIS FORM AND AVOID DELAYS, PLEASE MAKE SURE ALL AREAS ARE PROPERLY FILLED OUT.

ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

X

EMPLOYEE SIGNATURE DATE