











CT Member Enrollment & Physician Selection Form - OHP

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

Thank you for choosing Oxford Health Plans as the health plan for you and your family.

IMPORTANT!

Please print and press down firmly when completing this form. In order to process the attached Member Enrollment Form and begin coverage, all the following information must be completed accurately and in its entirety:

-  Date of Employment
-  Date of Marriage, if applicable
-  Date of Birth
-  Social Security Numbers
-  Primary Care Physician selections
-  Other coverage you or your spouse may have
-  Employer and Employee signatures are required at the bottom of form.
-  Complete the "Family Health Statement" when instructed by your Benefits Administrator.
-  If a dependent is a full-time college student at an accredited school, you must attach proof of full-time student status, such as a paid bill/tuition statement, an Oxford Student Verification Form, or a letter from the registration/bursar's office confirming enrollment.
-  Attach disability paperwork for dependents, if applicable

If you have any questions, please feel free to call our Customer Service Department at [1-800-444-6222](tel:1-800-444-6222).

Thank you again for choosing Oxford.



A UnitedHealthcare Company

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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 / /	IS THIS INDIVIDUAL ENROLLING UNDER COBRA? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, QUALIFYING EVENT	DATE OF QUALIFYING EVENT / /
PRODUCT SELECTED: <input type="checkbox"/> HMO <input type="checkbox"/> FREEDOM <input type="checkbox"/> LIBERTY <input type="checkbox"/> LIBERTY HMO <input type="checkbox"/> OTHER:	IS EMPLOYEE CURRENTLY ACTIVELY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	ON LEAVE OF ABSENCE? <input type="checkbox"/> YES <input type="checkbox"/> NO	RETIRED? <input type="checkbox"/> YES <input type="checkbox"/> NO
AVERAGE NUMBER OF HOURS WORKED PER WEEK	DATE OF FULL-TIME EMPLOYMENT / /	EMPLOYEE OCCUPATION	UNION/NON-UNION
EMPLOYER SIGNATURE X	DATE / /		

TO BE COMPLETED BY EMPLOYEE

EMPLOYEE LAST NAME	FIRST NAME & MI	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH / /
STREET ADDRESS	APT. NUMBER	HOME PHONE ()	BUSINESS PHONE ()
CITY	STATE ZIP	COUNTY	SOCIAL SECURITY NUMBER
OXFORD PRIMARY CARE PHYSICIAN	OXFORD CODE	IS THIS A NEW PHYSICIAN FOR YOU? <input type="checkbox"/> YES <input type="checkbox"/> NO	
OXFORD OB/GYN PROVIDER (FEMALE MEMBERS)	OXFORD OB/GYN CODE	IS THIS A NEW PHYSICIAN FOR YOU? <input type="checkbox"/> YES <input type="checkbox"/> NO	
TYPE OF COVERAGE: <input type="checkbox"/> SINGLE <input type="checkbox"/> FAMILY ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD? <input type="checkbox"/> PARENT / CHILD <input type="checkbox"/> HUSBAND / WIFE		SOCIAL SECURITY NUMBER OF POLICY HOLDER	COVERAGE DATES / / TO / /
LANGUAGE: <input type="checkbox"/> ENGLISH <input type="checkbox"/> SPANISH <input type="checkbox"/> CHINESE <input type="checkbox"/> OTHER:		COMMUNICATION PREFERENCE (PLEASE RANK IN ORDER FROM 1-4) __MAIL __FAX __PHONE __E-MAIL - ADDRESS:	PREFERRED TIME/ PLACE OF CONTACT <input type="checkbox"/> DAY <input type="checkbox"/> EVENING <input type="checkbox"/> HOME <input type="checkbox"/> OFFICE

EMPLOYEE'S DEPENDENT INFORMATION

SPOUSE'S LAST NAME	FIRST NAME & MI	DATE OF BIRTH / /	SOCIAL SECURITY NUMBER	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF MARRIAGE: / /
IS THIS DEPENDENT DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO	ANY OTHER HEALTH COVERAGE <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, NAME:	SOCIAL SECURITY NUMBER OF POLICY HOLDER	COVERAGE DATES / / TO / /		
SPOUSE'S EMPLOYER	SPOUSE'S OCCUPATION		DAYTIME PHONE ()		
OXFORD PRIMARY CARE PHYSICIAN	OXFORD CODE	IS THIS A NEW PHYSICIAN FOR YOU? <input type="checkbox"/> YES <input type="checkbox"/> NO			
OXFORD OB/GYN PROVIDER (FEMALE MEMBERS)	OXFORD OB/GYN CODE	IS THIS A NEW PHYSICIAN FOR YOU? <input type="checkbox"/> YES <input type="checkbox"/> NO			
ELIGIBLE CHILD'S LAST NAME	FIRST NAME & MI	DATE OF BIRTH / /	SOCIAL SECURITY NUMBER	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	AGE:
IS THIS DEPENDENT DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO	ANY OTHER HEALTH COVERAGE <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, NAME:	SOCIAL SECURITY NUMBER OF POLICY HOLDER	COVERAGE DATES / / TO / /		
OXFORD PRIMARY CARE PHYSICIAN	OXFORD CODE	IS THIS A NEW PHYSICIAN FOR YOU? <input type="checkbox"/> YES <input type="checkbox"/> NO			
OXFORD OB/GYN PROVIDER (FEMALE MEMBERS)	OXFORD OB/GYN CODE	IS THIS A NEW PHYSICIAN FOR YOU? <input type="checkbox"/> YES <input type="checkbox"/> NO			
ELIGIBLE CHILD'S LAST NAME	FIRST NAME & MI	DATE OF BIRTH / /	SOCIAL SECURITY NUMBER	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	AGE:
IS THIS DEPENDENT DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO	ANY OTHER HEALTH COVERAGE <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, NAME:	SOCIAL SECURITY NUMBER OF POLICY HOLDER	COVERAGE DATES / / TO / /		
OXFORD PRIMARY CARE PHYSICIAN	OXFORD CODE	IS THIS A NEW PHYSICIAN FOR YOU? <input type="checkbox"/> YES <input type="checkbox"/> NO			
OXFORD OB/GYN PROVIDER (FEMALE MEMBERS)	OXFORD OB/GYN CODE	IS THIS A NEW PHYSICIAN FOR YOU? <input type="checkbox"/> YES <input type="checkbox"/> NO			
ELIGIBLE CHILD'S LAST NAME	FIRST NAME & MI	DATE OF BIRTH / /	SOCIAL SECURITY NUMBER	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	AGE:
IS THIS DEPENDENT DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO	ANY OTHER HEALTH COVERAGE <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, NAME:	SOCIAL SECURITY NUMBER OF POLICY HOLDER	COVERAGE DATES / / TO / /		
OXFORD PRIMARY CARE PHYSICIAN	OXFORD CODE	IS THIS A NEW PHYSICIAN FOR YOU? <input type="checkbox"/> YES <input type="checkbox"/> NO			
OXFORD OB/GYN PROVIDER (FEMALE MEMBERS)	OXFORD OB/GYN CODE	IS THIS A NEW PHYSICIAN FOR YOU? <input type="checkbox"/> YES <input type="checkbox"/> NO			

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: <input type="checkbox"/> WHITE <input type="checkbox"/> AFRICAN AMERICAN/BLACK <input type="checkbox"/> HISPANIC/LATINO <input type="checkbox"/> ASIAN <input type="checkbox"/> OTHER:	SPOUSE: <input type="checkbox"/> WHITE <input type="checkbox"/> AFRICAN AMERICAN/BLACK <input type="checkbox"/> HISPANIC/LATINO <input type="checkbox"/> ASIAN <input type="checkbox"/> OTHER:
CHILD: <input type="checkbox"/> WHITE <input type="checkbox"/> AFRICAN AMERICAN/BLACK <input type="checkbox"/> HISPANIC/LATINO <input type="checkbox"/> ASIAN <input type="checkbox"/> OTHER:	CHILD: <input type="checkbox"/> WHITE <input type="checkbox"/> AFRICAN AMERICAN/BLACK <input type="checkbox"/> HISPANIC/LATINO <input type="checkbox"/> ASIAN <input type="checkbox"/> OTHER:
CHILD: <input type="checkbox"/> WHITE <input type="checkbox"/> AFRICAN AMERICAN/BLACK <input type="checkbox"/> HISPANIC/LATINO <input type="checkbox"/> ASIAN <input type="checkbox"/> OTHER:	

IN ORDER TO HELP US QUICKLY PROCESS THIS FORM AND AVOID DELAYS, PLEASE MAKE SURE ALL AREAS ARE PROPERLY FILLED OUT. IF YOU HAVE ADDITIONAL DEPENDENTS, PLEASE USE ANOTHER ENROLLMENT FORM TO PROVIDE THE NECESSARY INFORMATION.

I AUTHORIZE: DEDUCTIONS FROM MY EARNINGS FOR ANY REQUIRED CONTRIBUTIONS. I WILL DISCUSS ANY QUESTIONS CONCERNING THE PLAN WITH OXFORD'S CUSTOMER SERVICE DEPARTMENT. MY SIGNATURE BELOW AFFIRMS ELIGIBILITY FOR COVERAGE, AND THAT ALL INFORMATION PROVIDED IS FULL, COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE. 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 A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES UNDERSTAND THAT, IN ORDER TO RECEIVE HMO 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 FOR HMO BENEFITS, COVERED SERVICES WILL BE TREATED AS OUT-OF-NETWORK BENEFITS UNDER THE TERMS AND CONDITIONS OUTLINED IN THE CERTIFICATE.

EMPLOYEE/APPLICANT SIGNATURE (TO THE BEST OF MY KNOWLEDGE AND BELIEF) X	DATE / /
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