



Oxford Health Plans®

Addition/Termination/Change Form

Mailing Address: P.O. Box 7085 Bridgeport, CT 06601 • 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			
EMPLOYER	OXFORD GROUP ID NUMBER	CONTRACT SPECIFIC PACKAGE (CSP)	BILLING GROUP (BG)
<input checked="" type="checkbox"/> EMPLOYER SIGNATURE	DATE	OXFORD MEMBER ID NUMBER	

LAST NAME											FIRST NAME & MI										
STREET ADDRESS																					
CITY										STATE	ZIP	LANGUAGE SPOKEN, IF OTHER THAN ENGLISH									
<input checked="" type="checkbox"/> EMPLOYEE SIGNATURE																					

HEALTHCARE																	
<input type="checkbox"/> ADD SPOUSE TO PLAN EFFECTIVE (DATE)		REASON FOR ADDITION <input type="checkbox"/> NEWLY MARRIED - DATE OF MARRIAGE / / <input type="checkbox"/> OPEN ENROLLMENT <input type="checkbox"/> OTHER (PLEASE SPECIFY)															
SPOUSE'S LAST NAME				FIRST NAME AND MI				BIRTH DATE				SOCIAL SECURITY NUMBER				<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
WILL SPOUSE HAVE ANY OTHER HEALTH COVERAGE (INCL. MEDICARE)? <input type="checkbox"/> YES <input type="checkbox"/> NO				IF YES, NAME OF CARRIER				POLICY NUMBER				COVERAGE DATE(S) / / TO / /					
SPOUSE'S OXFORD PRIMARY CARE PHYSICIAN				OXFORD CODE				OXFORD OB/GYN PROVIDER (IF FEMALE)				OXFORD OB/GYN CODE					
<input type="checkbox"/> ADD DEPENDENT TO PLAN EFFECTIVE (DATE)		REASON FOR ADDITION <input type="checkbox"/> NEWBORN <input type="checkbox"/> OPEN ENROLLMENT <input type="checkbox"/> OTHER (PLEASE SPECIFY)															
LAST NAME				FIRST NAME AND MI				BIRTH DATE				SOCIAL SECURITY NUMBER				<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
WILL DEPENDENT HAVE ANY OTHER HEALTH COVERAGE (INCL. MEDICARE)? <input type="checkbox"/> YES <input type="checkbox"/> NO				IF YES, NAME OF CARRIER				POLICY NUMBER				COVERAGE DATE(S) / / TO / /					
DEPENDENT'S OXFORD PRIMARY CARE PHYSICIAN				OXFORD CODE				OXFORD OB/GYN PROVIDER (IF FEMALE)				OXFORD OB/GYN CODE					
<input type="checkbox"/> TERMINATE THE FOLLOWING INDIVIDUALS:		<input type="checkbox"/> EMPLOYEE <input type="checkbox"/> SPOUSE ONLY <input type="checkbox"/> DEPENDENT(S) ONLY <input type="checkbox"/> SPOUSE AND DEPENDENT(S) ONLY <input type="checkbox"/> FAMILY															
LAST DATE OF COVERAGE				REASON FOR TERMINATION <input type="checkbox"/> LEFT EMPLOYER <input type="checkbox"/> SWITCHED TO ANOTHER PLAN <input type="checkbox"/> DISCONTINUE COBRA <input type="checkbox"/> OTHER (PLEASE SPECIFY)													
<input type="checkbox"/> CHANGE EFFECTIVE (DATE)																	
LAST NAME				FIRST NAME AND MI				ADDRESS									
TELEPHONE (WORK)				TELEPHONE (HOME)				CITY				STATE		ZIP			
OXFORD PRIMARY CARE PHYSICIAN				OXFORD CODE				OXFORD OB/GYN PROVIDER (IF FEMALE)				OXFORD OB/GYN CODE					
<input type="checkbox"/> CHANGE TO COBRA:		<input type="checkbox"/> EMPLOYEE <input type="checkbox"/> EMPLOYEE AND SPOUSE <input type="checkbox"/> EMPLOYEE AND DEPENDENTS <input type="checkbox"/> SPOUSE ONLY <input type="checkbox"/> DEPENDENT(S) ONLY <input type="checkbox"/> SPOUSE AND DEPENDENT(S) ONLY <input type="checkbox"/> FAMILY															
QUALIFYING EVENT				DATE OF QUALIFYING EVENT / /				DATE COBRA EFFECTIVE (IMPORTANT NOTE: THIS FORM IS FOR USE ONLY BY GROUPS IN WHICH OXFORD HEALTH PLANS IS NOT ADMINISTERING COBRA.)									
<input type="checkbox"/> TRANSFER MEMBER'S SUBGROUP ID				OXFORD MEMBER ID NUMBER				EFFECTIVE DATE FROM				TO					
CONTRACT SPECIFIC PACKAGE (CSP)				BILLING GROUP (BG)				<input type="checkbox"/> OTHER				REASON					

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

<input checked="" type="checkbox"/>	
EMPLOYER SIGNATURE	DATE