



Oxford Health Plans®

Member Enrollment and Physician Selection Form

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

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

IMPORTANT!

In order to process the attached Member Enrollment form and begin coverage, all of the following information must be completed accurately and in its entirety:

- ✍ Date of Employment
- ✍ Date of Marriage
- ✍ Date of Birth
- ✍ Social Security Numbers
- ✍ Primary Care Physician selections
- ✍ Information on other coverage that you or your spouse may have
- ✍ Signature at the bottom of this form.

Note: Please press down firmly when completing this form.

If you have any questions, please feel free to call our Customer Service Department at 800-444-6222. Thank you for your cooperation.



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Member Enrollment and Physician Selection Form

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

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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 MO. DAY YEAR		IS INDIVIDUAL COVERED 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	
AVERAGE NO. OF HOURS WORKED PER WEEK		DATE OF FULL-TIME EMPLOYMENT MO. DAY YEAR		EMPLOYEE OCCUPATION		EMPLOYEE CLASSIFICATION <input type="checkbox"/> UNION <input type="checkbox"/> NON-UNION	
X EMPLOYER SIGNATURE				DATE MO. DAY YEAR			

To Be Completed By EMPLOYEE (Please Print)

LAST NAME		FIRST NAME & MI	
STREET ADDRESS		APT. NO. HOME PHONE () BUSINESS PHONE () HOME FAX () BUSINESS FAX ()	
CITY STATE ZIP		SOCIAL SECURITY NO COUNTY <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE BIRTH DATE MO. DAY YEAR	
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 <input type="checkbox"/> PARENT / CHILD <input type="checkbox"/> HUSBAND / WIFE		ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, CARRIER NAME	
LANGUAGE <input type="checkbox"/> ENGLISH <input type="checkbox"/> SPANISH <input type="checkbox"/> RUSSIAN <input type="checkbox"/> CHINESE <input type="checkbox"/> OTHER		SOCIAL SECURITY # OF POLICY HOLDER COVERAGE DATE(S) / / TO / /	
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 (Please Print)

SPOUSE'S LAST NAME		FIRST NAME AND MI		BIRTH DATE		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 (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, CARRIER NAME		SOCIAL SECURITY # OF POLICY HOLDER		COVERAGE DATE(S) / / 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 AND MI		BIRTH DATE		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 (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, CARRIER NAME		SOCIAL SECURITY # OF POLICY HOLDER		COVERAGE DATE(S) / / 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 AND MI		BIRTH DATE		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 (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, CARRIER NAME		SOCIAL SECURITY # OF POLICY HOLDER		COVERAGE DATE(S) / / 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 AND MI		BIRTH DATE		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 (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, CARRIER NAME		SOCIAL SECURITY # OF POLICY HOLDER		COVERAGE DATE(S) / / 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							

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 authorize: deductions from my earnings for any required contributions. I will discuss any questions concerning the plan with Oxford's member services. 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.

X

EMPLOYEE/APPLICANT SIGNATURE

DATE