



A UnitedHealthcare Company

NY Member Enrollment & Physician Selection Form - Oxford Health Plans (NY), Inc.

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

TO BE COMPLETED BY EMPLOYER

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	<input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, CARRIER NAME:	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:

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.

A I understand that my enrollment and benefits are in accordance with those described in the applicable Oxford Health Plans (NY), Inc. HMO Certificate. I 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 authorize any health provider or insurer to furnish Oxford Health Plans (NY), Inc. any records concerning me or any enrolled member of my family for whom information is requested. A photographic copy of this authorization shall be valid as the original. 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.

B I understand that in addition to the applicable Oxford Health Plans (NY) Inc. HMO Certificate, my enrollment and benefits are in accordance with those described in the applicable Oxford Health Insurance, Inc. Supplemental Freedom Plan Certificate. I 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, I will be eligible only for traditional health insurance coverage under the terms of the Oxford Health Insurance, Inc. Supplemental Freedom Plan 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	X	EMPLOYEE/APPLICANT SIGNATURE	DATE
OHPNY MEF LS 805		WHITE COPY: OXFORD	PINK COPY: OFFICE		YELLOW COPY: EMPLOYER
		GREEN COPY: EMPLOYEE/MEMBER		333 R6	