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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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? ❑ YES ❑ NO	IF YES, QUALIFYING EVENT	DATE OF QUALIFYING EVENT
PRODUCT SELECTED ❑ HMO ❑ Freedom ❑ Liberty ❑ Liberty HMO ❑ Other:	IS EMPLOYEE CURRENTLY ACTIVELY AT WORK? ❑ YES ❑ NO	ON LEAVE OF ABSENCE? ❑ YES ❑ NO	RETIRED? ❑ YES ❑ NO
AVERAGE NO. OF HOURS WORKED PER WEEK	DATE OF FULL-TIME EMPLOYMENT MO. DAY YEAR	EMPLOYEE OCCUPATION	EMPLOYEE CLASSIFICATION ❑ UNION ❑ 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	❑ MALE ❑ FEMALE	BIRTH DATE MO. DAY YEAR
OXFORD PRIMARY CARE PHYSICIAN		OXFORD CODE	IS THIS A NEW PHYSICIAN FOR YOU? ❑ YES ❑ NO	
OXFORD OB/GYN PROVIDER (Female Members)		OXFORD OB/GYN CODE	IS THIS A NEW PHYSICIAN FOR YOU? ❑ YES ❑ NO	
TYPE OF COVERAGE ❑ SINGLE ❑ FAMILY ❑ PARENT / CHILD ❑ HUSBAND / WIFE	ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD? ❑ YES ❑ NO IF YES, CARRIER NAME	SOCIAL SECURITY # OF POLICY HOLDER	COVERAGE DATE(S) / / TO / /	
LANGUAGE ❑ ENGLISH ❑ SPANISH ❑ RUSSIAN ❑ 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 (Please Print)

SPOUSE'S LAST NAME	FIRST NAME AND MI	BIRTH DATE	SOCIAL SECURITY NUMBER	❑ MALE ❑ FEMALE / DATE OF MARRIAGE / /
IS THIS DEPENDENT DISABLED? ❑ YES ❑ NO	ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD? ❑ YES ❑ 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? ❑ YES ❑ NO	
OXFORD OB/GYN PROVIDER (Female Members)		OXFORD OB/GYN CODE	IS THIS A NEW PHYSICIAN FOR YOU? ❑ YES ❑ NO	
ELIGIBLE CHILD'S LAST NAME	FIRST NAME AND MI	BIRTH DATE	SOCIAL SECURITY NUMBER	❑ MALE ❑ FEMALE / AGE
IS THIS DEPENDENT DISABLED? ❑ YES ❑ NO	ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD? ❑ YES ❑ 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? ❑ YES ❑ NO	
OXFORD OB/GYN PROVIDER (Female Members)		OXFORD OB/GYN CODE	IS THIS A NEW PHYSICIAN FOR YOU? ❑ YES ❑ NO	
ELIGIBLE CHILD'S LAST NAME	FIRST NAME AND MI	BIRTH DATE	SOCIAL SECURITY NUMBER	❑ MALE ❑ FEMALE / AGE
IS THIS DEPENDENT DISABLED? ❑ YES ❑ NO	ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD? ❑ YES ❑ 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? ❑ YES ❑ NO	
OXFORD OB/GYN PROVIDER (Female Members)		OXFORD OB/GYN CODE	IS THIS A NEW PHYSICIAN FOR YOU? ❑ YES ❑ NO	
ELIGIBLE CHILD'S LAST NAME	FIRST NAME AND MI	BIRTH DATE	SOCIAL SECURITY NUMBER	❑ MALE ❑ FEMALE / AGE
IS THIS DEPENDENT DISABLED? ❑ YES ❑ NO	ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD? ❑ YES ❑ 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? ❑ YES ❑ NO	
OXFORD OB/GYN PROVIDER (Female Members)		OXFORD OB/GYN CODE	IS THIS A NEW PHYSICIAN FOR YOU? ❑ YES ❑ 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