New York Member Enrollment Form – OHI

MAILING ADDRESS: P. O. Box 7085, Bridgeport CT 06601 • 1-800-444-6222 • *www.oxfordhealth.com*

UnitedHealthcare Oxford

A. Group Information (To be completed by the employer) — Please print neatly using black or blue ballpoint pen • ALL DATES MUST BE: MM/DD/YYYY

Group Number / Group Name	Plan CSP	Billing Group	Date of Hire	Effective Date	Occupation
			/ /	/ /	

☐ On Leave of Absence ☐ Retired
☐ Union Employee ☐ Disabled

COBRA/Young Adult/SC Qualifying Event — Event Date / /

Employer Signature: X [redacted] — Date: 01/18/2013

B. Applicant Details (To be completed by the employee)	Employee/Subscriber	Spouse	Child	Child
Social Security Number:				
Last Name:				
First Name, Middle Initial:				
Date of Birth: (MM/DD/YYYY)	/ /	/ /	/ /	/ /
Gender and Disability Status: (Check appropriate boxes.)	☐ M ☐ F / ☐ Disabled	☐ M ☐ F / ☐ Disabled	☐ M ☐ F / ☐ Disabled	☐ M ☐ F / ☐ Disabled
Primary Care Physician (PCP) ID Number: PCP Name: (If an existing patient of PCP, check "Yes".)	☐ Yes	☐ Yes	☐ Yes	☐ Yes
Check all that apply:		☐ Domestic Partner	☐ Full-time Student ☐ Young Adult	☐ Full-time Student ☐ Young Adult
Prior Carrier (List coverage prior to this.) — Carrier:	United Healthcare			
Policy Number:	[redacted]			
From Date	/ /	/ /	/ /	/ /
☒ Same for all — Thru date::	/ /	/ /	/ /	/ /

C. Coordination of Benefits		Employee/Subscriber	Spouse	Child	Child
Medicare Coverage	Check appropriate box and list effective date:	☐ Part A / / ☐ Part B / / ☐ Part D / /	☐ Part A / / ☐ Part B / / ☐ Part D / /	☐ Part A / / ☐ Part B / / ☐ Part D / /	☐ Part A / / ☐ Part B / / ☐ Part D / /
Pharmacy ☐ Same for all	Policy Number: Carrier: Policy Holder:				
Effective Date: / /	Group Number:	BIN: PCN:	BIN: PCN:	BIN: PCN:	BIN: PCN:
Medical ☐ Same for all	Policy Number: Carrier: Policy Holder:				
	Effective Date:	/ /	/ /	/ /	/ /

I understand that my enrollment and benefits are in accordance with those described in the Oxford Health Insurance Certificate. I understand that in order to receive in-network 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, I will be eligible only for out-of-network health insurance coverage under the terms of the 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. I authorize any health provider or insurer to furnish Oxford any research concerning me or any enrolled member of my family for whom information is requested.

Employee's/Young Adult's Address (Apt #)	Employee's/Young Adult's Signature	Date
City State Zip	X	/ /

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