Connecticut Member Enrollment Form – OHI

Oxford Health Insurance, Inc.
MAILING ADDRESS: P.O. Box 29142, Hot Springs, AR 71903 ▪ 1-800-444-6222 ▪ *www.oxfordhealth.com*

UnitedHealthcare®
Oxford

THANK YOU FOR CHOOSING AN OXFORD PRODUCT FOR YOU AND YOUR FAMILY.

IMPORTANT:

PLEASE PRINT AND PRESS DOWN FIRMLY WHEN COMPLETING THIS FORM.

IN ORDER TO PROCESS THE ATTACHED FORM AND BEGIN COVERAGE, EACH FIELD MUST BE COMPLETED ACCURATELY AND IN ITS ENTIRETY.

BE SURE TO:

- Use only black or blue ballpoint pen
- Enter all dates using the MM/DD/YYYY format
- Employer and employee signatures are required
- List any coordinating coverage (coverage in addition to this coverage)
- Complete the "Family Health Statement," if required
- Attach disability paperwork, if applicable
- Submit this form within 31 days of the requested effective date or within 60 days of the qualifying event for COBRA or State Continuation (SC)

In answering these questions, you should not include any genetic information. Please do not include any family medical history information or any information related to genetic services or genetic diseases for which you believe you may be at risk.

IF YOU HAVE ANY QUESTIONS, PLEASE FEEL FREE TO CALL CUSTOMER SERVICE AT

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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
☐ Actively at Work - Hours Per Week _____ ☐ Retired ☐ On Leave of Absence ☐ Union Employee ☐ Disabled	COBRA/SC Qualifying Event	Event Date / /	**Employer Signature** X	Date / /

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:		☐ Civil Union ☐ Domestic Partner		

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 Effective Date: / /	Policy Number: Carrier: Policyholder: Group Number:	BIN: PCN:	BIN: PCN:	BIN: PCN:	BIN: PCN:
Medical ☐ Same for all	Policy Number: Carrier: Policyholder: Effective Date:	/ /	/ /	/ /	/ /

I understand that my enrollments 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 primary care physician if required. Covered services will be treated as out-of-network benefits under the terms and conditions outlined in the Certificate. Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Employee's Address (Apt #)			**Preferred Phone:** ☐ **Home** ☐ **Cell** ☐ **Work** _____
City	**State**	**ZIP Code**	**Alternate Phone:** ☐ **Home** ☐ **Cell** ☐ **Work** _____
Email Address:	**Employee's Signature** X		**Date** / /