UnitedHealthcare
OXFORD

New Jersey Small Employer – Member Enrollment/Change Request Form – OHI

Oxford Health Insurance, Inc.
Mailing Address: P.O. Box 7085, Bridgeport, CT 06601-7085 1-800-444-6222 www.oxfordhealth.com

INSTRUCTIONS

Employers – You must complete the Employer Group Information and sections A and K in order for this application to be processed.

Employees – You must complete sections B through K and submit the signature of each Over-Age Child for which a Dependent Under 31 Continuation Election is made in accordance with Section J in order for this application to be processed.

- Please PRINT except when a signature is requested.
- If a dependent is disabled and you want to continue his or her coverage beyond the limiting age, you do not have to make a COBRA/NJSGC or Dependent Under 31 election. Instead, select "Other" in Section A3, and attach proof of disability.
- For provider addresses, include the zip code plus the four digit extension (11 digits)
- If a dependent is a full-time post-secondary student, you must check the box in Section D.
- You can obtain the providers' correct names and addresses from the appropriate provider directory.

Qualifying Events

COBRA and NJSGC
C1. Termination of job or reduction in hours
C2. Employee enrollment in Medicare (COBRA only)
C3. Divorce (COBRA/NJSGC); civil union dissolution (NJSGC)
C4. Death of employee
C5. Loss of dependent child status under the plan
C6. Disability (occurring subsequent to another qualifying event)

Dependent Under 31
D1. Loss of dependent status and otherwise eligible
D2. Reestablish eligibility: residency
D3. Reestablish eligibility: nonresident full-time student
D4. Reestablish eligibility: change in marital status
D5. Reestablish eligibility: change in parental status
D6. Reestablish eligibility: termination of other coverage

CONDITIONS OF ENROLLMENT - APPLICANT ACKNOWLEDGEMENTS AND AGREEMENTS

On behalf of myself and the dependents listed in this Enrollment/Change Request form, I acknowledge that:

1. I authorize any physician or medical professional, hospital, clinic or other medical care institution, carrier, consumer reporting agency, and any employer to give Oxford Health Plans, Inc., or any consumer reporting agency acting on behalf of Oxford Health Plans, Inc., information pertaining to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition relevant to me or a minor dependent applying for coverage. I agree that this authorization shall be valid for 30 months from the date I sign this Enrollment/Change Request form, unless revoked at an earlier date.
2. I agree that, if I revoke this authorization before it expires, such revocation shall not affect any action that Oxford Health Plans, Inc. has taken in reliance on the authorization.
3. I understand I may receive a copy of this authorization if I request one.
4. I agree Oxford Health Plans, Inc. will provide coverage in accordance with the terms of the contract for the group policy.
5. I agree that the provision of coverage and benefits is contingent upon payment of premiums and may be terminated in accordance with the terms of the group policy if premiums are not paid timely. I authorize my Employer to withhold payments from my wages as contribution to the premium, as appropriate.

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Group Information – To be completed by Employer:		
Group Name:	Group Number:	Contract Specific Package:

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A. Type of Activity – To be completed by Employer. ***Refer to instructions on cover before completing this form. Print clearly.***

	Activity – Check all that apply	Effective Date/ Date of Event	Date of Hire/Reason for Change
1. ADD	☐ Enrollment of a new Subscriber ☐ Add Spouse ☐ Civil Union Partner ☐ Add Domestic Partner ☐ Add Dependent Child ☐ Add Over-Age Child as a Dependent Under 31 *(and complete section A 4)*	_____/_____/_____ _____/_____/_____ _____/_____/_____ _____/_____/_____ _____/_____/_____ _____/_____/_____	Date of Hire: _____/_____/_____ _____ _____ _____ _____ _____
2. REMOVE	☐ Employee Withdrawal/Termination ☐ Remove Spouse ☐ Civil Union Partner ☐ Remove Domestic Partner ☐ Remove Dependent Child ☐ Remove Over-Age Child as a Dependent Under 31	_____/_____/_____ _____/_____/_____ _____/_____/_____ _____/_____/_____ _____/_____/_____ _____/_____/_____	_____ _____ _____ _____ _____ _____
3. OTHER CHANGE	☐ Name Change ☐ Change Plan ☐ Other ☐ Add/Change Office ID Numbers: Primary/OB/Gyn/ Dentist	_____/_____/_____ _____/_____/_____ _____/_____/_____ _____/_____/_____	_____ _____ _____ _____

4. COVERAGE CONTINUATION

☐ For Employee
- ☐ Total Disability*
- ☐ COBRA/NJSGC
  - Length of Continuation (in months):
  - ☐ 18 ☐ 29
  - Date of Loss of Coverage: ___/___/___
  - Qualifying Event #:_____**
  - Date of Qualifying Event: ___/___/___

Attach proof of disability

☐ For Spouse/Civil Union Partner*
- Length of Continuation (in months):
- ☐ 18 ☐ 36
- Date of Loss of Coverage: ___/___/___
- Qualifying Event #:_____**
- Date of Qualifying Event: ___/___/___

Civil union partners are eligible to make an election pursuant to NJSGC, if applicable.

☐ For Dependent or Over-age Child
- ☐ COBRA/NJSGC
  - Length of Continuation (in months):
  - ☐ 18 ☐ 36
  - Loss of Coverage: ___/___/___
  - Qualifying Event #:_____**
  - Date: ___/___/___
- ☐ Dependent Under 31
  - Qualifying Event #:_____**

** *Qualifying event #s: see list in Instructions.*

B. Employee Information – to be completed by the Employee

Name (Last, First, MI):

SSN:

Home

Street/Apt:_____

City:_____ State:_____ Zip Code: _____

Birthdate (mm/dd/yyyy):

☐ Male ☐ Female

Phone: (_____)_____

Work

Employer Name:_____

Address:_____

City:_____ State:_____ Zip Code: _____

Phone: (_____)_____

Employment Date: _____/_____/_____

Hours worked per week:_____

Activity

☐ Add ☐ Remove ☐ Continuation ☐ Other Change *If a name change, indicate prior name:*

Primary Name_____ Provider ID #: Current Patient: ☐ Yes ☐ No

Ob/Gyn Name_____ Provider ID #: Current Patient: ☐ Yes ☐ No

Dentist Name_____ Provider ID #: Current Patient: ☐ Yes ☐ No

Other Health Coverage? ☐ Yes ☐ No *If yes:*

Payer Name:

_____

Policy #: _____

Medicare ID#, if any:

Other Rx Coverage? ☐ Yes ☐ No *If yes:*

Payer Name: _____

Policy #: _____

Medicare ID#, if any:

Previous Coverage? ☐ Yes ☐ No

If Yes:

Effective date: _____/_____/_____ Termination date: _____/_____/_____

Payer Name:_____

Policy #:_____

C. Plan Option – To be completed by the Employee

Small Group:

☐ Freedom Plan®
☐ Freedom Plan® Direct℠
☐ Oxford MyPlan℠
☐ Liberty Plan℠
☐ Liberty Plan℠ Direct
☐ Oxford® HSA Direct℠
☐ Oxford USA℠

D. Other Individuals Covered – To be completed by the Employee. *Identify individuals other than yourself for whom you are adding/changing/removing/continuing coverage. Attach additional pages if necessary, dated and signed by you. Attach proof of disability.*

1. ☐Spouse ☐ Domestic Partner ☐Civil Union Partner	**2. Child** ☐ Full-Time Student	**3. Child** ☐ Full-Time Student	**4. Child** ☐ Full-Time Student
☐Add ☐ Remove ☐Other ☐Continue Spouse ☐Continue CU Partner (NJSGC)	☐ Add ☐ Remove ☐ Other ☐ Continue	☐ Add ☐ Remove ☐Other ☐ Continue	☐ Add ☐ Remove ☐Other ☐ Continue
Name (last, first, MI) L:____________________________ F:____________________________ MI:___________________________	Name (last, first, MI) L:____________________________ F:____________________________ MI:___________________________	Name (last, first, MI) L:____________________________ F:____________________________ MI:___________________________	Name (last, first, MI) L:____________________________ F:____________________________ MI:___________________________
Birthdate (mm/dd/yyyy):	Birthdate (mm/dd/yyyy):	Birthdate (mm/dd/yyyy):	Birthdate (mm/dd/yyyy):
☐ Male ☐ Female / ☐ Disabled	☐ Male ☐ Female / ☐ Disabled	☐ Male ☐ Female / ☐ Disabled	☐ Male ☐ Female / ☐ Disabled
Social Security Number:	Social Security Number:	Social Security Number:	Social Security Number:
Other Health Coverage ☐ Yes ☐ No *If yes:* Payer Name: _____________________________ Policy #: ____________________ Medicare ID #:________________	Other Health Coverage ☐ Yes ☐ No *If yes:* Payer Name: _____________________________ Policy #: ____________________ Medicare ID #:________________	Other Health Coverage ☐ Yes ☐ No *If yes:* Payer Name: _____________________________ Policy #: ____________________ Medicare ID #:________________	Other Health Coverage ☐ Yes ☐ No *If yes:* Payer Name: _____________________________ Policy #: ____________________ Medicare ID #:________________
Previous Coverage: ☐ Yes ☐ No *If yes:* Effective:____/____/___ Termination: ___/___/___ Payer Name: ______________________________ Policy #: _____________________	Previous Coverage: ☐ Yes ☐ No *If yes:* Effective:____/____/___ Termination: ___/___/___ Payer Name: ______________________________ Policy #: _____________________	Previous Coverage: ☐ Yes ☐ No *If yes:* Effective:____/____/___ Termination: ___/___/___ Payer Name: ______________________________ Policy #: _____________________	Previous Coverage: ☐ Yes ☐ No *If yes:* Effective:____/____/___ Termination: ___/___/___ Payer Name: ______________________________ Policy #: _____________________

Continue on next page

Continue from previous page

1. Spouse, Domestic Partner, Civil Union Partner	2. Child	3. Child	4. Child
Other Rx Coverage: ☐ Yes ☐ No *If yes:* Payer Name: _____ Policy #: _____ Medicare ID #:_____	Other Rx Coverage: ☐ Yes ☐ No *If yes:* Payer Name: _____ Policy #: _____ Medicare ID #:_____	Other Rx Coverage: ☐ Yes ☐ No *If yes:* Payer Name: _____ Policy #: _____ Medicare ID #:_____	Other Rx Coverage: ☐ Yes ☐ No *If yes:* Payer Name: _____ Policy #: _____ Medicare ID #:_____
Primary Care Provider: Provider ID #:_____ Current Patient? ☐ Yes ☐ No	Primary Care Provider: Provider ID #:_____ Current Patient? ☐ Yes ☐ No	Primary Care Provider: Provider ID #:_____ Current Patient? ☐ Yes ☐ No	Primary Care Provider: Provider ID #:_____ Current Patient? ☐ Yes ☐ No
Ob/Gyn Office Provider ID #:_____ Current Patient? ☐ Yes ☐ No	Ob/Gyn Office Provider ID #:_____ Current Patient? ☐ Yes ☐ No	Ob/Gyn Office Provider ID #:_____ Current Patient? ☐ Yes ☐ No	Ob/Gyn Office Provider ID #:_____ Current Patient? ☐ Yes ☐No
Dentist Office Provider ID #:_____ Current Patient? ☐ Yes ☐ No	Dentist Office Provider ID #:_____ Current Patient? ☐ Yes ☐ No	Dentist Office Provider ID #:_____ Current Patient? ☐ Yes ☐ No	Dentist Office Provider ID #:_____ Current Patient? ☐ Yes ☐ No
Employed? ☐ Yes ☐ No *If YES, complete Section E1*	If last name is different from Employee's, please explain: _____ _____	If last name is different from Employee's, please explain: _____ _____	If last name is different from Employee's, please explain: _____ _____
Home or billing addresses same as Employee? ☐ Yes ☐ No *If NO, complete Section E2*	Living with Employee? ☐ Yes ☐ No *If NO, complete Section F*	Living with Employee? ☐ Yes ☐ No *If NO, complete Section F*	Living with Employee? ☐ Yes ☐ No *If NO, complete Section F*

E. Additional Spouse/Civil Union Partner/Domestic Partner Information – To be completed by Employee. If *not applicable, please mark as "NA."*

1. Employer Name:_____
Employer Address:_____
City, State, Zip Code:_____
Employer Phone: ( )

2a.
Street/Apt:_____
City, State, Zip Code:_____

2b. Please explain why the address is different:
_____
_____

F. Additional Child Information – To be completed by Employee. *Provide information below about children listed in Section D,* **if** *they have a different address from the employee. If multiple children are at an address, you may list them together. Attach additional pages as necessary, dated and signed by you.*

Name(s):_____
Street/Apt:_____
Street/Apt:_____
City, State, Zip Code:_____
Reason:_____

Name(s):_____
Street/Apt:_____
Street/Apt:_____
City, State, Zip Code: _____
Reason:_____

G. Additional Information for Dependent Under 31 Continuation Elections – Provide information below about children listed in Section D for whom a Dependent Under 31 continuation election is being made.

This Continuation Election is being made:
☐ During Continuous Open Enrollment for Dependent Under 31 elections
☐ Within 30 days prior to the attainment of the limiting age (when the Dependent will become an Over-Age Child)

H. Race/Ethnicity – to be completed by the Employee, at his/her option. *NOTE: your response is appreciated but NOT required!*

Choose a category that most closely describes you:
☐ American Indian or Alaskan Native
☐ Asian or Pacific Islander
☐ Black, not of Hispanic origin
☐ White, not of Hispanic origin
☐ Hispanic

I. Employee Signature

I represent that all the information supplied in this application is true and complete. I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form. I authorize deductions from my earnings for any contributions required from me.

Signature: _____ Date: _____

J. Over-Age Child's Signature

I represent that all the information supplied in this application regarding the Dependent Under 31 Continuation Election is true and complete. I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form. I hereby agree to make contributions required from me for the Dependent Under 31 Continuation Election.

Signature: _____ Date: _____

K. Employer Verification

The requested activity is believed eligible and is approved by the Employer.
Employer Representative: _____ Date: _____

Representative's Title: _____