

New York Member Enrollment Form – OHI



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

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	
<input type="checkbox"/> On Leave of Absence	<input type="checkbox"/> Retired	COBRA/Young Adult/SC Qualifying		Event Date	Employer Signature		Date
<input type="checkbox"/> Union Employee	<input type="checkbox"/> Disabled	Event			X		/ /
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.)		<input type="checkbox"/> M <input type="checkbox"/> F / <input type="checkbox"/> Disabled	<input type="checkbox"/> M <input type="checkbox"/> F / <input type="checkbox"/> Disabled	<input type="checkbox"/> M <input type="checkbox"/> F / <input type="checkbox"/> Disabled	<input type="checkbox"/> M <input type="checkbox"/> F / <input type="checkbox"/> Disabled		
Primary Care Physician (PCP) ID Number:							
PCP Name: (If an existing patient of PCP, check "Yes".)		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes		
Check all that apply:		<input type="checkbox"/> Domestic Partner	<input type="checkbox"/> Full-time Student	<input type="checkbox"/> Full-time Student	<input type="checkbox"/> Full-time Student		
			<input type="checkbox"/> Young Adult	<input type="checkbox"/> Young Adult	<input type="checkbox"/> Young Adult		
Prior Carrier (List coverage prior to this.)		Carrier:	Policy Number:	From Date	Thru date:	/ /	/ /
<input type="checkbox"/> Same for all				/ /	/ /	/ /	/ /
C. Coordination of Benefits		Employee/Subscriber	Spouse	Child	Child		
Medicare Coverage	Check appropriate box and list effective date:	<input type="checkbox"/> Part A / / <input type="checkbox"/> Part B / / <input type="checkbox"/> Part D / /	<input type="checkbox"/> Part A / / <input type="checkbox"/> Part B / / <input type="checkbox"/> Part D / /	<input type="checkbox"/> Part A / / <input type="checkbox"/> Part B / / <input type="checkbox"/> Part D / /	<input type="checkbox"/> Part A / / <input type="checkbox"/> Part B / / <input type="checkbox"/> Part D / /		
Pharmacy	<input type="checkbox"/> Same for all	Policy Number:	Carrier:	Policy Holder:	Group Number:	BIN: PCN:	BIN: PCN:
Effective Date:	/ /						
Medical	<input type="checkbox"/> Same for all	Policy Number:	Carrier:	Policy Holder:	Effective Date:	/ /	/ /
<small>I warrant 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 services I and any family members must seek care through an Oxford affiliated primary care physician or through an Oxford-affiliated specialist or through an authorized referral from the primary care physician if required. I further warrant that I will not adhere to those requirements. I will be eligible only for out-of-network health insurance coverage under the terms of the Certificate. Any person who knowingly and willfully attempts to defraud any insurance company or other person files an application for insurance or statement of loss containing any material false information, or conceals the purpose of making information concerning any past or existing benefits, comes to 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 state value of the claim for each such violation. I warrant my health practice or account is listed. Oxford any records concerning me or any enrolled member of my family for claim administration is required.</small>							
Employee's/Young Adult's Address (Apt #)				Employee's/Young Adult's Signature		Date	
City	State	Zip	X		/ /		