



Oxford Health Plans[®]

New Jersey Small Member Enrollment/Change Request Form - OHP

Oxford Health Plans (NJ), Inc.

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

Instructions

Employer

- Complete the Employer Group Information in the upper right corner of the form.
- Section A - Type of Activity:** Check box(es) indicating reason(s) for submitting application.
- Complete **Section I Employer Verification** at the bottom of the form.
 - Employer must complete this section for all new enrollments, coverage changes and terminations.
 - Employer must sign and date the Enrollment/Change Request Form in order for it to be processed.

Employee - Complete Sections B-H

Section B - Employee Information:

- Complete all information in order for your application to be processed.

Section C - Plan Option:

- Indicate Plan Option selected and the type of contract.
- Select only an option offered by your employer.

Section D - Individuals Covered:

- Add/Change/Remove - Use "A", "C", or "R" to indicate whether you are adding, changing or removing coverage for an individual.
- Print your full name along with the name(s) of your dependent(s), if applicable. Indicate Sex, Birthdate, and Social Security Number for each individual listed.
- If a dependent is a full-time college student at an accredited school, you must attach proof of full-time student status, such as a paid bill/tuition statement, an Oxford Student Verification Form, or a letter from the registration/bursar's office confirming enrollment.
- If you or your dependent(s) have other health coverage, check off the "Yes" box(es) and complete Section F - Other/Previous Insurance.
- From the appropriate provider roster, locate the office ID number of the primary care physician, ob/gyn (if applicable) and/or dentist (if applicable). Indicate provider ID number selection(s) on the form.
- If you are a current patient, please check the "Current Patient" box.

Section E - Pre-Existing Conditions Statement:

- Complete this section for all new enrollments. **Exceptions:** For Small Employer Group coverage, this section must be completed only by persons enrolling in group coverage in a group of 2-5 employees and by late entrants.

Section F - Other/Previous Insurance:

- Complete this section for all new enrollments or coverage changes. Coverage includes group coverage, governmental coverage, a church plan or Medicare.

Section G - Dependent Information:

- Complete this section for all new enrollments or coverage changes.

Section H - Employee Signature:

- Complete this section for all new enrollments, coverage changes and terminations.
- Employee must sign and date the Enrollment/Change Request Form in order for it to be processed.

Section I - Employer Verification:

- Employer must complete this section for all new enrollments, coverage changes and terminations.
- Employer must sign and date the Enrollment/Change Request Form in order for it to be processed.

Conditions of Enrollment Applicant Acknowledgments and Agreements

On behalf of myself and the dependents listed on the attached form, I agree to or with the following:

- (a) I authorize the sources stated below to give to Oxford Health Plans (NJ), Inc. ("OHP"), or any consumer reporting agency acting on its behalf, information about me and my minor children, if applying for coverage. Such information will pertain to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition. Authorized sources are any physician or medical professional; any hospital, clinic or other medical care institution; any carrier; any consumer reporting agency; any employer.
 - (b) I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which OHP has taken in reliance on the authorization. I understand this authorization will not be valid after 30 months, if not revoked earlier.
 - (c) I know that I have a right to receive a copy of the authorization if I request one.
 - (d) I agree that a photocopy of this authorization is as valid as the original.
2. I acknowledge by enrolling in an OHP plan that coverage is provided by OHP in accordance with the contract.
3. Enrollment of myself and of the listed dependent(s) into the plan is effective on acceptance by OHP.
4. Coverage and benefits are contingent on timely payment of premiums and may be terminated as provided in the plan documents. My employer is hereby authorized to withhold payments from my wages, as appropriate.

Misrepresentation

5. Any person who includes any false or misleading information on an Enrollment/Change Request Form for a health benefits plan is subject to criminal and civil penalties.

F. Other/Previous Insurance

Is your spouse employed? Yes No

If "yes", give name and address of your spouse's employer:

If "yes" to Other Health Coverage (Section D), give name and policy number of insurance carrier, HMO, or other source. If enrolled in Medicare Parts A and/or B, identify the coverage and provide the Medicare ID#:

If "yes" to previous coverage, identify names of persons, give effective date and date coverage terminated, name of previous carrier and plan number:

G. Dependent Information

Does any dependent listed in Section D live at a different address than the employee? Yes No

If "yes", who and at what address?

Explain the circumstances:

If any dependent's last name differs from yours, explain the circumstances.

H. Employee Signature

If you have questions concerning the benefits and services provided by or excluded under this contract, contact a Customer Service representative at 1-800-444-6222 before signing this form.

I represent that all the information supplied in this Enrollment/Change Request Form is true and complete. I hereby agree to the conditions of enrollment on the employee copy of the Enrollment/Change/Request Form. I authorize deductions from my earnings for any required contributions.

Employee Signature – Required

X

Date

E-mail Address _____

I. Employer Verification - To Be Completed by EMPLOYER

Employer Signature – Required

X

Title

Date

Employee copy may be used as a temporary ID card for 30 days from the effective date if authorized by employer. Coverage must be verified with Oxford Health Plans prior to visiting a specialist or admission to a hospital.