

- I previously refused/waived coverage
- I am enrolling for coverage during my employer's open enrollment period. Open enrollment date: _____
- I am continuing under _____ Federal Law (COBRA) or _____ State Law
 Qualifying Event: _____ Date Continuation began: _____
 Continuation applies to: _____ Employee Only _____ Employee and Eligible Dependents
- I am continuing under a total disability extension (Attach proof of disability)
- I am terminating coverage for myself and all dependents
- I am adding/deleting dependent(s)
- Other (specify) _____

If you are declining enrollment for yourself or your dependents (including your spouse) because of other Group Health Plan coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

SECTION II: COVERAGE INFORMATION

1. Persons to be covered: Employee Only Employee & Spouse Employee & Child(ren) Employee, Spouse & Child(ren)

2. Please provide all information for each person to be covered or deleted:

Full Name (Last, First, Middle Initial)	Add	Delete	Sex	Social Security No.	Birthdate
Employee					
Spouse					
Child					
Child					
Child					
Child					

Attach a separate sheet to list additional children. Attach proof if full-time student. Attach proof of disability.

3. Do any of the dependents listed above live at an address other than the Home address given above? Yes No

If "Yes", name the dependent(s) and provide the address(es). _____

Explain the circumstances. _____

4. If any dependents last name differs from yours, explain the circumstances.

5. Are any of the dependents listed above confined in a facility or at home, due to a medical reason? Yes No

If "Yes", name the dependent(s), and the place and reason for confinement. _____

SECTION II: CONTINUED

6. Indicate whether any person to be covered is enrolled under Medicare, Parts A and/or B.

	Part A		Part B		Medicare I.D. Number
Employee	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Spouse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Child (give name) _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____

7. Which coverage have you selected to be primary in the event expenses are incurred as a result of an automobile related injury?

Auto Medical

8. Are you, or any person to be covered, eligible for other health coverage?

(i.e., employer sponsored group coverage, Medicare, Medicaid) Yes No

If "Yes", indicate the name(s) of the person(s), the name(s) of the carrier(s), the policy number(s) and the type(s) of coverage.

9. Are you replacing existing coverage? Yes No

If "Yes", give the name and policy number of the replaced carrier, the effective and termination dates, and the names(s) of the persons covered by the policy. _____

10. Were you, or any dependent(s) to be covered under a prior Group Health Plan? Yes No

If "Yes", attach the Certificate of Group Health Plan Coverage

Please note that if you do not provide the Certificate of Group Health Plan Coverage, you and any dependents to be covered, may be required to satisfy the pre-existing conditions limitation, if applicable.

SECTION III: HEALTH CARE SELECTION

(If you are enrolling in the Liberty Plan PPO do not complete this section)

Full Name (Last, First, Middle Initial)	Primary Care Physician	Oxford ID #	OB/GYN	Oxford ID #
Employee				
Spouse				
Child				
Child				
Child				
Child				

NOTE: A Primary Care Physician **must be selected** for each adult member and a Pediatrician must be selected for each child. Woman over the age of 16 must also select a OB/GYN.

Plan Selection: _____

SECTION IV: PRE-EXISTING CONDITIONS STATEMENT

Note: This information may ONLY be used to determine if a condition is a pre-existing condition. You CANNOT be denied coverage under a health benefits plan on the basis of accurate responses to the following questions. Carriers can only use the information to expedite the processing of claims. However, benefits, services or supplies for the treatment of a pre-existing condition may be limited for 90 days. This limitation of benefits, services and supplies applies only to employer groups with 2-5 employees and to late enrollees. Consult the agent or carrier for information on the waiving of this limitation under circumstances as provided under New Jersey Law.

- 1. During the past 6 months have you, or any dependent to be covered had, or been diagnosed as having:**
- | | Yes | No |
|---|--------------------------|--------------------------|
| a. Alcoholism or Drug Abuse | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Arthritis | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Blood Disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Back or Neck Disorder, Injury or Pain | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Cancer or Tumors | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Gastro or Intestinal Disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Heart Disorder or Condition or Chest Pains | <input type="checkbox"/> | <input type="checkbox"/> |
| i. High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Kidney or Liver Disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Lung or Respiratory Disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Mental or Nervous Disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| m. Paralysis, Stroke or Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> |

- 2. During the past 6 months, have you or any dependent to be covered:**
- | | | |
|--|--------------------------|--------------------------|
| a. been examined or treated by a physician or other health care provider for any condition, illness or injury, other than as stated above? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. been advised to have treatment or surgery or testing that has not been done? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. been admitted to a hospital or other health care facility as an inpatient? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. taken prescribed medication(s)? | <input type="checkbox"/> | <input type="checkbox"/> |

Please give details of any "Yes" answers to any parts of questions 1 or 2. Attach a separate sheet if more space is needed for answers. The separate sheet should be signed and dated.

Question Number and Letter	Name of Person	Condition	Duration of Symptoms, Treatment, Degree of Recovery	Date	Name and Address of Hospitals, Practitioners

SECTION V: DECLARATION AND AUTHORIZATION

I hereby enroll for the group coverage to which I am or may be entitled. I authorize deductions from my pay for my share of the cost, if any.

I represent that to the best of my knowledge and belief, the statements and answers given above are true and complete. I understand that the information shall form the basis upon which I may be included for coverage under the group plan.

I understand that:

- a. the coverage applied for will not take effect unless:
 - after review of this Enrollment Form, Oxford Health Insurance, Inc. (OHI) accepts it;
 - the first premium has been paid to Oxford Health Insurance, Inc.; and
 - I am either actively at work for full pay on a full-time basis on the date coverage is to take effect, or subject to applicable regulations, I qualify under for a waiver of the active work requirement
- b. no person, except an officer of OHI has authority to: determine whether certificate shall be issued based on this Enrollment Form; waive or modify any of the provisions of the Enrollment Form or any of OHI's requirements; to bind OHI by any statement or promise pertaining to any certificate to be issued on the basis of this Enrollment Form; or accept any information or representation not contained in the written Enrollment Form.
- c. the Employer is hereby designated my representative for the purpose of receiving contributions and remitting them to OHI.
- d. OHI does not pay benefits for charges, or provide services or supplies related to a pre-existing condition for 180 days, measured from the enrollment date. I understand that a Pre-Existing Condition is an Illness or Injury which manifests itself in the six months before a person's Enrollment Date, and for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the Enrollment Date. I also understand that New Jersey Law only permits the application of the pre-existing conditions limitation under certain circumstances and that I or my dependents will only be subject to this limitation to the extent permitted by New Jersey Law.

Unless I request otherwise in writing, I understand that by signing below when I file a claim, OHI may pay the health care benefits directly to the provider instead of to me.

I state that I am a resident of New Jersey and I live, reside or work within OHI's service area. I understand that if I omit or falsify any statement on this enrollment form, OHI can cancel my coverage as of the original effective date.

Any person who includes any false or misleading information on an application or enrollment form for a health benefits plan is subject to criminal and civil penalties.

Note: A person who was covered under Creditable Coverage has a right to request a certificate from the prior plan or issuer to demonstrate that he or she was covered under Creditable Coverage. If necessary, OHI will assist the person in obtaining a certificate from the prior plan or issuer.

AUTHORIZATION

1. I authorize the sources stated below to give to OHI, 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, 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.
2. I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which OHI has taken in reliance on the authorization. I understand this authorization will not be valid after 30 months, if not revoked earlier.
3. I know that I have a right to receive a copy of this authorization if I request one.
4. I agree that a photocopy of this authorization is as valid as the original.

(Date Signed)

(Signature of Employee)

(Date Signed)

(Signature of Spouse, if providing information on the pre-existing conditions statement)

(Date Signed)

(Signature of Child who is age 18 or older, if providing information on the pre-existing conditions statement)



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