



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 K 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.



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	<input type="checkbox"/> Enrollment of a new Subscriber	___/___/___	Date of Hire: ___/___/___
	<input type="checkbox"/> Add Spouse	___/___/___	_____
	<input type="checkbox"/> Civil Union Partner	___/___/___	_____
	<input type="checkbox"/> Add Domestic Partner	___/___/___	_____
	<input type="checkbox"/> Add Dependent Child	___/___/___	_____
	<input type="checkbox"/> Add Over-Age Child as a Dependent Under 31 (and complete section A 4)	___/___/___	_____
2. REMOVE	<input type="checkbox"/> Employee Withdrawal/Termination	___/___/___	_____
	<input type="checkbox"/> Remove Spouse	___/___/___	_____
	<input type="checkbox"/> Civil Union Partner	___/___/___	_____
	<input type="checkbox"/> Remove Domestic Partner	___/___/___	_____
	<input type="checkbox"/> Remove Dependent Child	___/___/___	_____
	<input type="checkbox"/> Remove Over-Age Child as a Dependent Under 31	___/___/___	_____
3. OTHER CHANGE	<input type="checkbox"/> Name Change	___/___/___	_____
	<input type="checkbox"/> Change Plan	___/___/___	_____
	<input type="checkbox"/> Other	___/___/___	_____
	<input type="checkbox"/> Add/Change Office ID Numbers: Primary/OB/Gyn/ Dentist	___/___/___	_____
4. COVERAGE CONTINUATION	<input type="checkbox"/> For Employee <input type="checkbox"/> Total Disability* <input type="checkbox"/> COBRA/NJSGC Length of Continuation (in months): <input type="checkbox"/> 18 <input type="checkbox"/> 29 Date of Loss of Coverage: ___/___/___ Qualifying Event #: _____** Date of Qualifying Event: ___/___/___	<input type="checkbox"/> For Spouse/Civil Union Partner* Length of Continuation (in months): <input type="checkbox"/> 18 <input type="checkbox"/> 36 Date of Loss of Coverage: ___/___/___ Qualifying Event #: _____** Date of Qualifying Event: ___/___/___ <i>*Civil union partners are eligible to make an election pursuant to NJSGC, if applicable.</i>	<input type="checkbox"/> For Dependent or Over-age Child <input type="checkbox"/> COBRA/NJSGC Length of Continuation (in months): <input type="checkbox"/> 18 <input type="checkbox"/> 36 Loss of Coverage: ___/___/___ Qualifying Event #: _____** Date: ___/___/___ <input type="checkbox"/> Dependent Under 31 Qualifying Event #: _____**
	<i>*Attach proof of disability</i> <i>** Qualifying event #s: see list in Instructions.</i>		

B. Employee Information – to be completed by the Employee		Name (Last, First, MI): _____	SSN: _____
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Home	Street/Apt: _____	Birthdate (mm/dd/yyyy): _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
	City: _____ State: _____ Zip Code: _____	Phone: (____) _____	

Work	Employer Name: _____	Phone: (____) _____
	Address: _____ City: _____ State: _____ Zip Code: _____	Employment Date: ____/____/____ Hours worked per week: _____

Activity	<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Continuation <input type="checkbox"/> Other Change <i>If a name change, indicate prior name:</i>		
	Primary Name _____	Provider ID #: _____	Current Patient: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Ob/Gyn Name _____	Provider ID #: _____	Current Patient: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Dentist Name _____	Provider ID #: _____	Current Patient: <input type="checkbox"/> Yes <input type="checkbox"/> No

Other Health Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes:</i> Payer Name: _____ Policy #: _____ Medicare ID#, if any: _____	Other Rx Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes:</i> Payer Name: _____ Policy #: _____ Medicare ID#, if any: _____
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Previous Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If Yes:</i> Effective date: ____/____/____ Termination date: ____/____/____	Payer Name: _____ Policy #: _____
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C. Plan Option – To be completed by the Employee			
Small Group:	<input type="checkbox"/> Freedom Plan [®]	<input type="checkbox"/> Liberty Plan SM	<input type="checkbox"/> Oxford USA SM
	<input type="checkbox"/> Freedom Plan [®] Direct SM	<input type="checkbox"/> Liberty Plan SM Direct	
	<input type="checkbox"/> Oxford MyPlan SM	<input type="checkbox"/> Oxford [®] HSA Direct SM	

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. <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Civil Union Partner	2. Child <input type="checkbox"/> Full-Time Student	3. Child <input type="checkbox"/> Full-Time Student	4. Child <input type="checkbox"/> Full-Time Student
<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Other <input type="checkbox"/> Continue Spouse <input type="checkbox"/> Continue CU Partner (NJSGC)	<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Other <input type="checkbox"/> Continue	<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Other <input type="checkbox"/> Continue	<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Other <input type="checkbox"/> 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): <input type="checkbox"/> Male <input type="checkbox"/> Female / <input type="checkbox"/> Disabled	Birthdate (mm/dd/yyyy): <input type="checkbox"/> Male <input type="checkbox"/> Female / <input type="checkbox"/> Disabled	Birthdate (mm/dd/yyyy): <input type="checkbox"/> Male <input type="checkbox"/> Female / <input type="checkbox"/> Disabled	Birthdate (mm/dd/yyyy): <input type="checkbox"/> Male <input type="checkbox"/> Female / <input type="checkbox"/> Disabled
Social Security Number:	Social Security Number:	Social Security Number:	Social Security Number:
Other Health Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: Payer Name: _____ Policy #: _____ Medicare ID #: _____	Other Health Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: Payer Name: _____ Policy #: _____ Medicare ID #: _____	Other Health Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: Payer Name: _____ Policy #: _____ Medicare ID #: _____	Other Health Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: Payer Name: _____ Policy #: _____ Medicare ID #: _____
Previous Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: Effective: ___/___/___ Termination: ___/___/___ Payer Name: _____ Policy #: _____	Previous Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: Effective: ___/___/___ Termination: ___/___/___ Payer Name: _____ Policy #: _____	Previous Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: Effective: ___/___/___ Termination: ___/___/___ Payer Name: _____ Policy #: _____	Previous Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: Effective: ___/___/___ Termination: ___/___/___ Payer Name: _____ Policy #: _____

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1. Spouse, Domestic Partner, Civil Union Partner	2. Child	3. Child	4. Child
Other Rx Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: Payer Name: _____	Other Rx Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: Payer Name: _____	Other Rx Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: Payer Name: _____	Other Rx Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: Payer Name: _____
Policy #: _____ Medicare ID #: _____	Policy #: _____ Medicare ID #: _____	Policy #: _____ Medicare ID #: _____	Policy #: _____ Medicare ID #: _____
Primary Care Provider: Provider ID #: _____	Primary Care Provider: Provider ID #: _____	Primary Care Provider: Provider ID #: _____	Primary Care Provider: Provider ID #: _____
Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No Ob/Gyn Office Provider ID #: _____	Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No Ob/Gyn Office Provider ID #: _____	Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No Ob/Gyn Office Provider ID #: _____	Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No Ob/Gyn Office Provider ID #: _____
Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No Dentist Office Provider ID #: _____	Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No Dentist Office Provider ID #: _____	Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No Dentist Office Provider ID #: _____	Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No Dentist Office Provider ID #: _____
Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Employed? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If NO, complete Section E2	Living with Employee? <input type="checkbox"/> Yes <input type="checkbox"/> No If NO, complete Section E	Living with Employee? <input type="checkbox"/> Yes <input type="checkbox"/> No If NO, complete Section E	Living with Employee? <input type="checkbox"/> Yes <input type="checkbox"/> No If NO, complete Section E

E. Additional Spouse/Civil Union Partner/Domestic Partner Information – To be completed by Employee. If <i>not applicable</i> , 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. <i>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.</i>		
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: <input type="checkbox"/> During Continuous Open Enrollment for Dependent Under 31 elections <input type="checkbox"/> 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. <i>NOTE: your response is appreciated but NOT required!</i>	<i>Choose a category that most closely describes you:</i> <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Black, not of Hispanic origin <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> White, not of Hispanic origin	
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: _____	