

Dental Enrollment Form

Oxford Health Plans, Inc.

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

Plan Type: Premium Enhanced

To Be Completed By Employer			(Please Print)
GROUP NAME	GROUP ID NUMBER	EMPLOYEE'S EFFECTIVE DATE OF COVERAGE / /	
EMPLOYER SIGNATURE X			

To Be Completed By EMPLOYEE										(Please Print)	
LAST NAME					FIRST NAME & MI						
STREET ADDRESS				APT. NO.		HOME PHONE			BUSINESS PHONE		
CITY			STATE	ZIP	SOCIAL SECURITY NUMBER				<input type="checkbox"/> MALE	DATE OF BIRTH	
									<input type="checkbox"/> FEMALE	MO. DAY YEAR	
PRIMARY CARE DENTIST NAME*				PROVIDER CODE							

Dependent Information										(Please Print)	
SPOUSE'S LAST NAME					FIRST NAME					MI	<input type="checkbox"/> MALE
											<input type="checkbox"/> FEMALE
PRIMARY CARE DENTIST NAME*			PROVIDER CODE		SOCIAL SECURITY NUMBER				DATE OF BIRTH		
									MO. DAY YEAR		
ELIGIBLE CHILD'S LAST NAME					FIRST NAME					MI	<input type="checkbox"/> MALE
											<input type="checkbox"/> FEMALE
PRIMARY CARE DENTIST NAME*			PROVIDER CODE		SOCIAL SECURITY NUMBER				DATE OF BIRTH		
									MO. DAY YEAR		
ELIGIBLE CHILD'S LAST NAME					FIRST NAME					MI	<input type="checkbox"/> MALE
											<input type="checkbox"/> FEMALE
PRIMARY CARE DENTIST NAME*			PROVIDER CODE		SOCIAL SECURITY NUMBER				DATE OF BIRTH		
									MO. DAY YEAR		
ELIGIBLE CHILD'S LAST NAME					FIRST NAME					MI	<input type="checkbox"/> MALE
											<input type="checkbox"/> FEMALE
PRIMARY CARE DENTIST NAME*			PROVIDER CODE		SOCIAL SECURITY NUMBER				DATE OF BIRTH		
									MO. DAY YEAR		

* You must select a General Practice (GP) Dentist from Oxford's Roster of Participating Dentists for each family member.

Do you or your spouse have any other Group Dental Coverage? Yes No If yes, please give:

Name of Group Administrator/Plan _____ Policy # _____

I understand that my enrollment and benefits are in accordance with those described in the Oxford's Dental Rider. I agree to choose a participating Oxford General Practice Dentist for my primary dental care and to seek any necessary specialty care through Oxford participating Dental Specialists. I authorize any provider or insurer to furnish Oxford with any records concerning me or any member of my family for whom information is required. A photographic copy of this authorization shall be as valid as the original. I agree to submit any disputes with Oxford in accordance with the Oxford Health Plans Contract. I authorize my employer to deduct from my wages the amount required (if any) to cover my contribution for coverage. I certify that I and any of my dependents have no other dental insurance other than that listed above. I certify that all the above information is correct.

X EMPLOYEE SIGNATURE	DATE
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