



A UnitedHealthcare Company

Healthy New York Member Enrollment Form

Mailing Address: Attn: Healthy New York Department, 14 Central Park Drive, Hooksett, NH 03106 • 1-800-216-0778

Thank you for choosing Oxford Health Plans.

IMPORTANT!

In order to process the attached Member Enrollment form and begin coverage, all of the following information must be completed accurately and in its entirety:

INCOMPLETE FORMS WILL BE RETURNED.

By the Employer

- ✍ Group Number
- ✍ Date of Employment
- ✍ Employer Signature
- ✍ Effective Date of Coverage

By the Employee

- ✍ Date of Marriage
- ✍ Date of Birth
- ✍ Social Security Numbers
- ✍ Primary Care Physician selections
- ✍ Information on other coverage
- ✍ Signature at the bottom of the form
- ✍ Mailing Address, including Zip Code

Note: Please press down firmly when completing this form.

If you have any questions, please feel free to call our Member Service Department at 800-216-0778. Thank you for your cooperation.



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Please do not write in this area, for Oxford use only.

To Be Completed By EMPLOYER (Please Print)

NAME OF GROUP (EMPLOYER)		GROUP NUMBER	
EMPLOYEE'S EFFECTIVE DATE OF COVERAGE MO. DAY YEAR	IS INDIVIDUAL COVERED UNDER COBRA? IF YES, QUALIFYING EVENT <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE OF QUALIFYING EVENT MO. DAY YEAR	
DATE OF EMPLOYMENT MO. DAY YEAR	AVERAGE NO. OF HOURS WORKED PER WEEK	EMPLOYEE OCCUPATION: <input type="checkbox"/> EXECUTIVE <input type="checkbox"/> MANAGEMENT <input type="checkbox"/> NON-MANAGEMENT <input type="checkbox"/> HOURLY <input type="checkbox"/> OTHER (PLEASE SPECIFY)	EMPLOYEE CLASSIFICATION <input type="checkbox"/> UNION <input type="checkbox"/> NON-UNION
X EMPLOYER SIGNATURE			DATE

To Be Completed By EMPLOYEE (Please Print)

SOCIAL SECURITY NO.	LAST NAME	
FIRST NAME	MI	BIRTH DATE MO. DAY YEAR
<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		HOME PHONE () ()
BUSINESS PHONE () ()		
STREET ADDRESS		APT. NO. CITY STATE ZIP
WILL YOU HAVE ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, CARRIER NAME		NAME OF POLICY HOLDER POLICY START DATE / /
OXFORD CODE OF PRIMARY CARE PHYSICIAN SELECTED	ARE YOU AN EXISTING PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	PRIOR HEALTH INSURANCE INFORMATION: CARRIER NAME
OXFORD CODE OF OB/GYN SELECTED (Female Members)	ARE YOU AN EXISTING PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	COVERAGE BEGIN DATE / / COVERAGE END DATE / /

EMPLOYEE'S Dependent Information (Please Print)

SPOUSE'S SOCIAL SECURITY NUMBER		SPOUSE'S LAST NAME		SPOUSE'S FIRST NAME		MI
SPOUSE'S BIRTH DATE MO. DAY YEAR		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF MARRIAGE MO. DAY YEAR		SPOUSE'S EMPLOYER	
WILL YOU HAVE ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, CARRIER NAME		NAME OF POLICY HOLDER			POLICY START DATE / /	
OXFORD CODE OF PRIMARY CARE PHYSICIAN SELECTED	ARE YOU AN EXISTING PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	PRIOR HEALTH INSURANCE INFORMATION: CARRIER NAME				
OXFORD CODE OF OB/GYN SELECTED (Female Members)	ARE YOU AN EXISTING PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	COVERAGE BEGIN DATE / / COVERAGE END DATE / /				
ELIGIBLE CHILD'S SOCIAL SECURITY NO.	ELIGIBLE CHILD'S LAST NAME		ELIGIBLE CHILD'S FIRST NAME		MI	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
ELIGIBLE CHILD'S BIRTH DATE MO. DAY YEAR	IS THIS DEPENDENT DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO	WILL YOU HAVE ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD? <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, CARRIER NAME:		NAME OF POLICY HOLDER		POLICY START DATE / /
OXFORD CODE OF PRIMARY CARE PHYSICIAN SELECTED	ARE YOU AN EXISTING PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	PRIOR HEALTH INSURANCE INFORMATION: CARRIER NAME				
OXFORD CODE OF OB/GYN SELECTED (Female Members)	ARE YOU AN EXISTING PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	COVERAGE BEGIN DATE / / COVERAGE END DATE / /				
ELIGIBLE CHILD'S SOCIAL SECURITY NO.	ELIGIBLE CHILD'S LAST NAME		ELIGIBLE CHILD'S FIRST NAME		MI	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
ELIGIBLE CHILD'S BIRTH DATE MO. DAY YEAR	IS THIS DEPENDENT DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO	WILL YOU HAVE ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD? <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, CARRIER NAME:		NAME OF POLICY HOLDER		POLICY START DATE / /
OXFORD CODE OF PRIMARY CARE PHYSICIAN SELECTED	ARE YOU AN EXISTING PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	PRIOR HEALTH INSURANCE INFORMATION: CARRIER NAME				
OXFORD CODE OF OB/GYN SELECTED (Female Members)	ARE YOU AN EXISTING PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	COVERAGE BEGIN DATE / / COVERAGE END DATE / /				
ELIGIBLE CHILD'S SOCIAL SECURITY NO.	ELIGIBLE CHILD'S LAST NAME		ELIGIBLE CHILD'S FIRST NAME		MI	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
ELIGIBLE CHILD'S BIRTH DATE MO. DAY YEAR	IS THIS DEPENDENT DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO	WILL YOU HAVE ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD? <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, CARRIER NAME:		NAME OF POLICY HOLDER		POLICY START DATE / /
OXFORD CODE OF PRIMARY CARE PHYSICIAN SELECTED	ARE YOU AN EXISTING PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	PRIOR HEALTH INSURANCE INFORMATION: CARRIER NAME				
OXFORD CODE OF OB/GYN SELECTED (Female Members)	ARE YOU AN EXISTING PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	COVERAGE BEGIN DATE / / COVERAGE END DATE / /				
ELIGIBLE CHILD'S SOCIAL SECURITY NO.	ELIGIBLE CHILD'S LAST NAME		ELIGIBLE CHILD'S FIRST NAME		MI	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
ELIGIBLE CHILD'S BIRTH DATE MO. DAY YEAR	IS THIS DEPENDENT DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO	WILL YOU HAVE ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD? <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, CARRIER NAME:		NAME OF POLICY HOLDER		POLICY START DATE / /
OXFORD CODE OF PRIMARY CARE PHYSICIAN SELECTED	ARE YOU AN EXISTING PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	PRIOR HEALTH INSURANCE INFORMATION: CARRIER NAME				
OXFORD CODE OF OB/GYN SELECTED (Female Members)	ARE YOU AN EXISTING PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	COVERAGE BEGIN DATE / / COVERAGE END DATE / /				

If you have additional dependents, please use another enrollment form to provide the necessary information. In order to help us quickly process this form and avoid delays, please make sure all areas are properly filled out.

I understand that my enrollment and benefits are in accordance with those described in the applicable Oxford Health Plans (NY), Inc. HMO Certificate. I understand that, in order to qualify for HMO benefits, I and any enrolled dependents must choose an Oxford affiliated physician for primary care and secure a referral from that physician to an Oxford-affiliated specialist physician for all specialist care. I authorize any health provider or insurer to furnish Oxford Health Plans (NY), Inc. any records concerning me or any enrolled member of my family for whom information is requested. A photographic copy of this authorization shall be valid as the original.

I understand that any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits 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 stated value of the claim for each such violation

X EMPLOYEE/APPLICANT SIGNATURE	DATE
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