



A UnitedHealthcare Company

# Dental Enrollment Form

Oxford Health Plans, Inc.

Mailing Address: P.O. Box 7085, Bridgeport, CT 06601-7085 • Local Address: 48 Monroe Turnpike, Trumbull, CT 06611 • 1-800-444-6222 • www.oxfordhealth.com

Plan Type:  Premium  Enhanced

**To Be Completed By Employer (Please Print)**

GROUP NAME	OXFORD GROUP ID NUMBER	EMPLOYEE'S EFFECTIVE DATE OF COVERAGE / /
EMPLOYER SIGNATURE <b>X</b>		

**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		
OXFORD 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	
OXFORD 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	
OXFORD 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	
OXFORD 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	
OXFORD 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 in addition to Oxford?  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 Health Plans 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 Health Plans 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 \_\_\_\_\_