



# Oxford Health Plans<sup>®</sup>

## Pennsylvania Member Enrollment Form

Oxford Health Insurance, Inc.

**Mailing Address:** P.O. Box 7085, Bridgeport, CT 06601 • 800-444-6222 **Corporate Address:** 48 Monroe Turnpike, Trumbull CT 06611 • [www.oxfordhealth.com](http://www.oxfordhealth.com)

Thank you for choosing Oxford Health Plans as the health plan for you and your family.

### 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
- ✍ Contract Specific Package (CSP)
- ✍ Billing Group (BG)
- ✍ Date of Full-Time Employment
- ✍ Employer Signature
- ✍ Effective Date of Coverage

#### By the Employee

- ✍ Date of Employment
- ✍ Date of Marriage
- ✍ Date of Birth
- ✍ Social Security Numbers
- ✍ Information on other coverage that you or your spouse may have
- ✍ 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 800-444-6222. Thank you for your cooperation.



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| To Be Completed By EMPLOYER   |  |  |   | (Please Print)   |
|---|--|--|---|--|
| NAME OF GROUP (EMPLOYER)  |  | GROUP NUMBER   | CONTRACT SPECIFIC PACKAGE (CSP)   | BILLING GROUP (BG)   |
| EMPLOYEE'S EFFECTIVE DATE OF COVERAGE<br>MO. DAY YEAR   |  | IS INDIVIDUAL COVERED UNDER COBRA?<br><input type="checkbox"/> YES <input type="checkbox"/> NO | IF YES, QUALIFYING EVENT  | DATE OF QUALIFYING EVENT   |
| PRODUCT SELECTED <input type="checkbox"/> Freedom Plan Direct <input type="checkbox"/> Other: |  | IS EMPLOYEE CURRENTLY  | ACTIVELY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO | ON LEAVE OF ABSENCE?<br><input type="checkbox"/> YES <input type="checkbox"/> NO             |
| AVERAGE NO. OF HOURS WORKED PER WEEK  |  | DATE OF FULL-TIME EMPLOYMENT<br>MO. DAY YEAR   | EMPLOYEE OCCUPATION   | EMPLOYEE CLASSIFICATION<br><input type="checkbox"/> UNION <input type="checkbox"/> NON-UNION |
| X EMPLOYER SIGNATURE  |  |  | DATE<br>MO. DAY YEAR  |  |

| To Be Completed By EMPLOYEE   |  |                              |   | (Please Print)             |
|---|--|------------------------------|---|----------------------------|
| LAST NAME   |  | FIRST NAME & MI              |   |                            |
| STREET ADDRESS  |  | APT. NO.                     | HOME PHONE  | BUSINESS PHONE             |
| CITY  |  | STATE                        | ZIP   | COUNTY                     |
| TYPE OF COVERAGE<br><input type="checkbox"/> SINGLE <input type="checkbox"/> FAMILY <input type="checkbox"/> PARENT / CHILD <input type="checkbox"/> HUSBAND / WIFE       |  | SOCIAL SECURITY NO.          | <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE | BIRTH DATE<br>MO. DAY YEAR |
| PRIOR HEALTH INSURANCE INFORMATION<br>Carrier name:   |  | COVERAGE DATES<br>/ / TO / / |   | POLICY NO.                 |
| WILL YOU HAVE ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD?<br><input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, CARRIER NAME |  |                              | NAME OF POLICY HOLDER   | POLICY START DATE<br>/ /   |

| EMPLOYEE'S Dependent Information  |  |   |  | (Please Print)   |
|---|--|---|--|--|
| SPOUSE'S SOCIAL SECURITY NUMBER   |  | SPOUSE'S LAST NAME  |  | SPOUSE'S FIRST NAME MI   |
| SPOUSE'S BIRTH DATE<br>MO. DAY YEAR   |  | <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE | DATE OF MARRIAGE<br>MO. DAY YEAR   | SPOUSE'S EMPLOYER  |
| WILL YOU HAVE ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD?<br><input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, CARRIER NAME |  |   | NAME OF POLICY HOLDER  | POLICY START DATE<br>/ /   |
| PRIOR HEALTH INSURANCE INFORMATION<br>Carrier name:   |  | COVERAGE DATES<br>/ / TO / /                                  |  | POLICY NO.   |
| 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<br>MO. DAY YEAR   |  | <input type="checkbox"/> YES <input type="checkbox"/> NO      | WILL YOU HAVE ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD?<br><input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, CARRIER NAME: | NAME OF POLICY HOLDER  |
| PRIOR HEALTH INSURANCE INFORMATION<br>Carrier name:   |  | COVERAGE DATES<br>/ / TO / /                                  |  | POLICY NO.   |
| 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<br>MO. DAY YEAR   |  | <input type="checkbox"/> YES <input type="checkbox"/> NO      | WILL YOU HAVE ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD?<br><input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, CARRIER NAME: | NAME OF POLICY HOLDER  |
| PRIOR HEALTH INSURANCE INFORMATION<br>Carrier name:   |  | COVERAGE DATES<br>/ / TO / /                                  |  | POLICY NO.   |
| 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<br>MO. DAY YEAR   |  | <input type="checkbox"/> YES <input type="checkbox"/> NO      | WILL YOU HAVE ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD?<br><input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, CARRIER NAME: | NAME OF POLICY HOLDER  |
| PRIOR HEALTH INSURANCE INFORMATION<br>Carrier name:   |  | COVERAGE DATES<br>/ / TO / /                                  |  | POLICY NO.   |

| ACCEPTING OR DECLINING INSURANCE | (Please Sign) |
|----------------------------------|---------------|
|----------------------------------|---------------|

I understand that my enrollments and benefits are in accordance with those described in the Oxford Health Insurance Certificate. I understand that, in order to receive in-network benefits, I and any enrolled dependents must seek care through Oxford affiliated primary care physician or through an Oxford-affiliated specialist physician. I further understand that if do not adhere to these requirements, I will be eligible only for out-of-network health insurance coverage under the terms of this certificate.

Any person who knowingly and with 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 subjects such person to criminal and civil penalties.

X \_\_\_\_\_ DATE

EMPLOYEE/APPLICANT SIGNATURE  
WHITE COPY: OXFORD PINK COPY: OFFICE YELLOW COPY: EMPLOYER GREEN COPY: EMPLOYEE/MEMBER