



A UnitedHealthcare Company  
Oxford Health Insurance Inc.

## Connecticut Member Enrollment Form - OHI

**Mailing Address:** P.O. Box 7085, Bridgeport, CT 06601 • 1-800-444-6222 • [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 Marriage
- ✍ Date of Birth
- ✍ Social Security Numbers
- ✍ Primary Care Physician selections (not required for Freedom Plan Select and Oxford USA plans)
- ✍ Information on other coverage that you or your spouse may have
- ✍ Signature at the bottom of the form
- ✍ Mailing Address, including Zip Code

\* Please complete the enclosed "Family Health Statement." when instructed by your Benefits Administrator.

**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.

# Connecticut Member Enrollment Form - OHI

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

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

**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 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 FULL-TIME 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
<input checked="" type="checkbox"/> 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 / /		IS MEMBER DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO			
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 only complete for dependents who will be covered on your Oxford policy (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			IS THIS DEPENDENT DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO		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 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 our Oxford affiliated primary care physician or through an Oxford-affiliated specialist physician with an authorized referral from the primary care physician if required. Covered services will be treated as Out-of-network benefits under the terms and conditions outlined in the Certificate.

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

<input checked="" type="checkbox"/> EMPLOYEE/APPLICANT SIGNATURE	DATE
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