Connecticut Member Enrollment Form – OHP

MAILING ADDRESS: P.O. Box 29142, Hot Springs, AR 71903 ▪ *www.oxfordhealth.com*

UnitedHealthcare Oxford

THANK YOU FOR CHOOSING AN OXFORD PRODUCT
FOR YOU AND YOUR FAMILY.

IMPORTANT:

PLEASE PRINT AND PRESS DOWN FIRMLY WHEN COMPLETING THIS FORM.

IN ORDER TO PROCESS THE ATTACHED FORM AND BEGIN COVERAGE, EACH FIELD MUST BE COMPLETED ACCURATELY AND IN ITS ENTIRETY.

BE SURE TO:

- Use only black or blue ballpoint pen
- Enter all dates using the MM/DD/YYYY format
- Employer and employee signatures are required
- List any coordinating coverage (coverage in addition to this coverage)
- Complete the “Family Health Statement,” if required
- Attach disability paperwork, if applicable
- Submit this form within 31 days of the requested effective date or within 60 days of the qualifying event for COBRA or State Continuation (SC)

In answering these questions, you should not include any genetic information. Please do not include any family medical history information or any information related to genetic services or genetic diseases for which you believe you may be at risk.

IF YOU HAVE ANY QUESTIONS,
PLEASE FEEL FREE TO CALL CUSTOMER SERVICE AT

1-800-444-6222

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A. Group Information (To be completed by the employer)

Group Number Group Name	Plan CSP Billing Group	Date of Hire / /	Effective Date / /	Occupation
☐ Actively at Work - Hours Per Week _____ ☐ Retired ☐ On Leave of Absence ☐ Union Employee ☐ Disabled	COBRA/SC Qualifying Event	Event Date / /	**Employer Signature** X	Date / /

B. Applicant Details (To be completed by the employee)

	Employee/Subscriber	Spouse	Child	Child
Social Security Number:				
Last Name:				
First Name, Middle Initial:				
Date of Birth: (MM/DD/YYYY)	/ /	/ /	/ /	/ /
Gender and Disability Status: (Check appropriate boxes)	☐ M ☐ F / ☐ Disabled	☐ M ☐ F / ☐ Disabled	☐ M ☐ F / ☐ Disabled	☐ M ☐ F / ☐ Disabled
Primary Care Physician (PCP) ID Number: PCP Name: (If an existing patient of PCP, check "Yes.")	☐ Yes	☐ Yes	☐ Yes	☐ Yes
Check all that apply:		☐ Civil Union ☐ Domestic Partner ☐ Actively Working		

C. Coordination of Benefits

		Employee/Subscriber	Spouse	Child	Child
Medicare Coverage	Check appropriate box and list effective date:	☐ Part A / / ☐ Part B / / ☐ Part D / /	☐ Part A / / ☐ Part B / / ☐ Part D / /	☐ Part A / / ☐ Part B / / ☐ Part D / /	☐ Part A / / ☐ Part B / / ☐ Part D / /
Pharmacy ☐ Same for all Effective Date: / /	Policy Number: Carrier: Policyholder: Group Number:	BIN: PCN:	BIN: PCN:	BIN: PCN:	BIN: PCN:
Medical ☐ Same for all	Policy Number: Carrier: Policyholder: Effective Date:	/ /	/ /	/ /	/ /

I authorize deductions from my earnings for any required contributions. I will discuss any questions that I have about the plan with the Oxford Customer Service Department. My signature below affirms eligibility for coverage, and that all information provided is full, complete and true to the best of my knowledge. 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 concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. I understand that, in order to receive HMO 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. I further understand that if I do not adhere to these requirements for HMO benefits, covered services will be treated as out-of-network benefits under the terms and conditions outlined in the Certificate.

Employee's Address	**(Apt #)**	**Employee's Signature**	**Date**
		X	/ /
City	**State**	**ZIP Code**	