New Jersey Small Employer – Member Enrollment/Change Request Form – Oxford Health Insurance, Inc. (OHI) or Oxford Health Plans (NJ), Inc. (OHP)

UnitedHealthcare Oxford

Group Information – To be completed by **employer:**

Group Name:	Group Number:	Plan CSP/Plan ID:

Oxford Health Insurance, Inc. or Oxford Health Plans (NJ), Inc.
Mailing Address: P.O. Box 31391, Salt Lake City, UT 84131 1-800-444-6222

A. Type of Activity – To be completed by **employer.** *Refer to instructions on page 4 before completing this form. Print clearly.*

	Activity – Check all that apply	Effective Date/ Date of Event	Date of Hire/Reason for Change
1. Add	☐ Enrollment of a new Subscriber		Date of Hire:
	☐ Add Spouse		
	☐ Add Civil Union Partner		
	☐ Add Domestic Partner		
	☐ Add Dependent Child		
	☐ Add Over-Age Child as a Dependent Under 31 *(and complete section A 4)*		
2. Remove	☐ Employee Withdrawal/Termination		
	☐ Remove Spouse		
	☐ Remove Civil Union Partner		
	☐ Remove Domestic Partner		
	☐ Remove Dependent Child		
	☐ Remove Over-Age Child as a Dependent Under 31		
3. Other change	☐ Name Change		
	☐ Change Plan		
	☐ Other		
	☐ Add/Change Office ID Numbers: Primary/OB/Gyn		

4. Coverage continuation

☐ For Employee
- ☐ Total Disability*
- ☐ COBRA/NJSGC
  - Length of Continuation (in months):
  - ☐ 18 ☐ 29
  - Date of Loss of Coverage:_____
  - Qualifying Event #:_____**
  - Date of Qualifying Event:_____

Attach proof of disability.

☐ For Spouse/Civil Union Partner*/ Domestic Partner
- Length of Continuation (in months):
- ☐ 18 ☐ 36
- Date of Loss of Coverage:_____
- Qualifying Event #:_____**
- Date of Qualifying Event:_____

Civil union partners are eligible to make an election pursuant to NJSGC, if applicable.

☐ For Dependent or Over-age Child
- ☐ COBRA/NJSGC
  - Length of Continuation (in months):
  - ☐ 18 ☐ 36
  - Loss of Coverage: _____
  - Qualifying Event #:_____**
  - Date: _____
- ☐ Dependent Under 31
  - Qualifying Event #:_____**

**Qualifying event #s: see list in Instructions

B. Employee Information – To be completed by the **employee**

Name (Last, First, MI):	SSN:	Birthdate (mm/dd/yyyy):	☐ Male ☐ Female

Home

Street/Apt: _____
Street/Apt: _____
City:_____ State:_____ ZIP Code:_____
Preferred Phone: ☐ Home ☐ Cell ☐ Work_____ Alternate Phone: ☐ Home ☐ Cell ☐ Work _____
Email: _____

Work

Employer Name: _____
Address: _____
City:_____ State: _____ ZIP Code: _____
Phone: _____ Email: _____

Employment Date:
_____

Hours worked per week:
_____

B. Employee Information – To be completed by the **employee** (continued)

Activity			
☐ Add ☐ Remove ☐ Continuation ☐ Other Change *If a name change, indicate prior name:*			
	Primary Name:	Provider #:	Current Patient: ☐ Yes ☐ No
	Ob/Gyn Name:	Provider #:	Current Patient: ☐ Yes ☐ No

Other Health Coverage? ☐ Yes ☐ No

If yes: Payer Name: _____ Policy #: _____

Medicare ID#, if any: _____

C. Plan Option – To be completed by the **employee**

OHI	☐ EPO Gated (Freedom Network) ☐ EPO Gated (Liberty Network) ☐ EPO Gated (Metro Network)	☐ EPO Non-gated (Freedom Network) ☐ EPO Non-gated (Liberty Network) ☐ EPO Non-gated (Metro Network)	☐ EPO HSA (Liberty Network) ☐ EPO HSA (Metro Network) ☐ PPO HSA (Freedom Network) ☐ PPO HSA (Liberty Network)	☐ PPO Non-gated (Freedom Network) ☐ PPO Non-gated (Liberty Network) ☐ Other Plan _____
OHP	☐ Silver HMO (Liberty Network)	☐ Other Plan		

D. Other Individuals Covered - To be completed by the **employee.** *Identify individuals other than yourself for whom you are adding/changing/removing/continuing coverage. Attach additional pages if necessary, with your signature and dated. Attach proof of disability.*

1. ☐ Spouse ☐ Domestic Partner(DP) ☐ Civil Union (CU) Partner	2. Child	3. Child	4. Child
☐ Add ☐ Remove ☐ Other ☐ Continue Spouse ☐ Continue Civil Union Partner (NJSGC) ☐ Continue Domestic Partner (NJSGC)	☐ Add ☐ Remove ☐ Other ☐ Continue	☐ Add ☐ Remove ☐ Other ☐ Continue	☐ Add ☐ Remove ☐ Other ☐ Continue
Name (last, first, MI) L:	Name (last, first, MI) L:	Name (last, first, MI) L:	Name (last, first, MI) L:
F:	F:	F:	F:
MI:	MI:	MI:	MI:
Birthdate (mm/dd/yyyy):	Birthdate (mm/dd/yyyy):	Birthdate (mm/dd/yyyy):	Birthdate (mm/dd/yyyy):
☐ Male ☐ Female / ☐ Disabled	☐ Male ☐ Female / ☐ Disabled	☐ Male ☐ Female / ☐ Disabled	☐ Male ☐ Female / ☐ Disabled
Social Security Number:	Social Security Number:	Social Security Number:	Social Security Number:
Other Health Coverage: ☐ Yes ☐ No If yes: Payer Name:	Other Health Coverage: ☐ Yes ☐ No If yes: Payer Name:	Other Health Coverage: ☐ Yes ☐ No If yes: Payer Name:	Other Health Coverage: ☐ Yes ☐ No If yes: Payer Name:
Policy#:	Policy#:	Policy#:	Policy#:
Medicare ID#:	Medicare ID#:	Medicare ID#:	Medicare ID#:
Primary Care Provider: Name:	Primary Care Provider: Name:	Primary Care Provider: Name:	Primary Care Provider: Name:
Provider ID#:	Provider ID#:	Provider ID#:	Provider ID#:
Current Patient? ☐ Yes ☐ No	Current Patient? ☐ Yes ☐ No	Current Patient? ☐ Yes ☐ No	Current Patient? ☐ Yes ☐ No
OB/Gyn: Name:	OB/Gyn: Name:	OB/Gyn: Name:	OB/Gyn: Name:
Provider ID#:	Provider ID#:	Provider ID#:	Provider ID#:
Current Patient? ☐ Yes ☐ No	Current Patient? ☐ Yes ☐ No	Current Patient? ☐ Yes ☐ No	Current Patient? ☐ Yes ☐ No
Employed? ☐ Yes ☐ No *If Yes, complete Section E1*	If last name is different from Employee's, please explain:	If last name is different from Employee's, please explain:	If last name is different from Employee's, please explain:
Home or billing address same as Employee? ☐ Yes ☐ No *If No, complete Section E2*	Living with Employee ☐ Yes ☐ No If No, complete Section F	Living with Employee ☐ Yes ☐ No If No, complete Section F	Living with Employee ☐ Yes ☐ No If No, complete Section F

E. Additional Spouse/Civil Union Partner/Domestic Partner Information - To be completed by the **employee.**
If not applicable, please mark as "NA".

1.

Employer Name: _____

Employer Address: _____

City, State, ZIP Code: _____ Employer Phone: _____

2a.

Street/Apt: _____

Street/Apt: _____

City, State, ZIP Code: _____

2b.

Please explain why the address is different:

_____

_____

F. Additional Child Information - To be completed by the **employee.** *Provide information below about children listed in Section D, if they have a different address from the employee. If multiple children are at an address, you may list them together. Attach additional pages as necessary, signed and dated.*

Name(s): _____

Street/Apt: _____

Street/Apt: _____

City, State, ZIP Code: _____

Reason:_____

Name(s): _____

Street/Apt: _____

Street/Apt: _____

City, State, ZIP Code: _____

Reason:_____

G. Race/Ethnicity - To be completed by the **employee,** at his/her option. *NOTE: your response is appreciated but NOT required!*

Choose a category that most closely describes you:

☐ American Indian or Alaskan Native ☐ Black, not of Hispanic origin ☐ Hispanic ☐ Asian or Pacific Islander ☐ White, not of Hispanic origin

H. Employee Signature

I represent that all the information supplied in this application is true and complete. I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form. I authorize deductions from my earnings for any contributions required from me.

Signature: Date:

I. Over-Age Child's Signature

I represent that all the information supplied in this application regarding the Dependent Under 31 Continuation Election is true and complete. I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form. I hereby agree to make contributions required from me for the Dependent Under 31 Continuation Election.

Signature: Date:

J. Employer Verification

The requested activity is believed eligible and is approved by the Employer. If termination of coverage is requested, the Employer certifies that no employee contributions have been taken for any period subsequent to the requested termination date.

Employer Representative: Date:

Representative's Title:

Instructions

Employers – You must complete the Employer Group Information and sections A and J in order for this application to be processed.

Employees – You must complete sections B through H and submit the signature of each Over-Age Child for which a Dependent Under 31 Continuation Election is made in accordance with Section I in order for this application to be processed.

- Please PRINT except when a signature is requested.
- f a dependent is disabled and you want to continue his or her coverage beyond age 26, you do not have to make a COBRA/ NJSGC or Dependent Under 31 election. Instead, select “Other” in Section A3, and attach proof of disability.
- For provider addresses, include the zip code plus the four digit extension (11 digits)
- You can obtain the providers’ correct names and addresses from the appropriate provider directory.

Qualifying Events

COBRA and NJSGC

C1. Termination of job or reduction in hours

C2. Employee enrollment in Medicare (COBRA only)

C3. Divorce (COBRA/NJSGC); civil union dissolution (NJSGC)

C4. Death of employee

C5. Loss of dependent child status under the plan

C6. Disability (occurring subsequent to another qualifying event)

Dependent Under 31

D1. Loss of dependent status and otherwise eligible

D2. Reestablish eligibility: residency

D3. Reestablish eligibility: nonresident full-time student

D4. Reestablish eligibility: change in marital status

D5. Reestablish eligibility: change in parental status

D6. Reestablish eligibility: termination of other coverage

Conditions of Enrollment – Applicant Acknowledgements and Agreements

On behalf of myself and the dependents listed in this Enrollment/Change Request form, I acknowledge that:

1. I authorize any physician or medical professional, hospital, clinic or other medical care institution, carrier, consumer reporting agency, and any employer to give Oxford Health Insurance, Inc. or Oxford Health Plans, Inc., or any consumer reporting agency acting on behalf of Oxford Health Insurance, Inc. or Oxford Health Plans, Inc., information pertaining to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition relevant to me or a minor dependent applying for coverage. I agree that this authorization shall be valid for 30 months from the date I sign this Enrollment/Change Request form, unless revoked at an earlier date.

2. I agree that, if I revoke this authorization before it expires, such revocation shall not affect any action that Oxford Health Insurance, Inc. or Oxford Health Plans, Inc. has taken in reliance on the authorization.

3. I understand I may receive a copy of this authorization if I request one.

4. I agree Oxford Health Insurance, Inc. or Oxford Health Plans, Inc. will provide coverage in accordance with the terms of the contract for the group policy.

5. I agree that the provision of coverage and benefits is contingent upon payment of premiums and may be terminated in accordance with the terms of the group policy if premiums are not paid timely. I authorize my Employer to withhold payments from my wages as contribution to the premium, as appropriate.