



## New Jersey Small Employer – Member Enrollment/Change Request Form – OHI

Oxford Health Insurance, Inc.

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

### INSTRUCTIONS

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

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

- Please PRINT except when a signature is requested.
- If a dependent is disabled and you want to continue his or her coverage beyond the limiting age, 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)
- If a dependent is a full-time post-secondary student, you must check the box in Section D.
- 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 acting on behalf of 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 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 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.



Group Information – To be completed by Employer:

Group Name:	Group Number:	Contract Specific Package:
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**A. Type of Activity – To be completed by Employer. Refer to instructions on cover before completing this form. Print clearly.**

Activity – Check all that apply

Date of Hire/Reason for Change

	Effective Date/ Date of Event	Date of Hire: ___/___/___
<b>1. ADD</b>	<input type="checkbox"/> Enrollment of a new Subscriber <input type="checkbox"/> Add Spouse <input type="checkbox"/> Civil Union Partner <input type="checkbox"/> Add Domestic Partner <input type="checkbox"/> Add Dependent Child <input type="checkbox"/> Add Over-Age Child as a Dependent Under 31 (and complete section A 4)	_____ _____ _____ _____ _____ _____
<b>2. REMOVE</b>	<input type="checkbox"/> Employee Withdrawal/Termination <input type="checkbox"/> Remove Spouse <input type="checkbox"/> Civil Union Partner <input type="checkbox"/> Remove Domestic Partner <input type="checkbox"/> Remove Dependent Child <input type="checkbox"/> Remove Over-Age Child as a Dependent Under 31	_____ _____ _____ _____ _____ _____
<b>3. OTHER CHANGE</b>	<input type="checkbox"/> Name Change <input type="checkbox"/> Change Plan <input type="checkbox"/> Other <input type="checkbox"/> Add/Change Office ID Numbers: Primary/OB/Gyn/ Dentist	_____ _____ _____ _____ _____ _____

	For Spouse/Civil Union Partner*	For Dependent or Over-age Child
<b>4. COVERAGE CONTINUATION</b>	<input type="checkbox"/> For Employee <input type="checkbox"/> Total Disability* <input type="checkbox"/> COBRA/NJSGC Length of Continuation (in months): <input type="checkbox"/> 18 <input type="checkbox"/> 29 Date of Loss of Coverage: ___/___/___** Qualifying Event #: _____** Date of Qualifying Event: ___/___/___	<input type="checkbox"/> For Spouse/Civil Union Partner* Length of Continuation (in months): <input type="checkbox"/> 18 <input type="checkbox"/> 36 Date of Loss of Coverage: ___/___/___** Qualifying Event #: _____** Date of Qualifying Event: ___/___/___

\*Attach proof of disability  
 \*\* Qualifying event #s: see list in Instructions.

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

<b>B. Employee Information – to be completed by the Employee</b>		Name (Last, First, MI):		SSN:	
Street/Apt: _____		Birthdate (mm/dd/yyyy):		<input type="checkbox"/> Male <input type="checkbox"/> Female	
City: _____ State: _____ Zip Code: _____		Phone: (____) _____			
<b>Work</b>		Employer Name: _____		Phone: (____) _____	
Address: _____		Employment Date: ____/____/____		Hours worked per week: _____	
City: _____ State: _____ Zip Code: _____					
<b>Activity</b>		<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Continuation <input type="checkbox"/> Other Change <i>If a name change, indicate prior name:</i>		Provider ID #: _____ Current Patient: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Primary Name _____		Ob/Gyn Name _____		Current Patient: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Dentist Name _____		Provider ID #: _____		Current Patient: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Other Health Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes:</i>		Other Rx Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes:</i>			
Payer Name: _____		Payer Name: _____		Payer Name: _____	
Policy #: _____		Policy #: _____		Policy #: _____	
Medicare ID#, if any: _____		Medicare ID#, if any: _____		Medicare ID#, if any: _____	
Previous Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No		Termination date: ____/____/____			
Effective date: ____/____/____					
<b>C. Plan Option – To be completed by the Employee</b>					
Small Group:		<input type="checkbox"/> Freedom Plan <sup>SM</sup> <input type="checkbox"/> Freedom Plan <sup>SM</sup> Direct <input type="checkbox"/> Oxford MyPlan <sup>SM</sup>		<input type="checkbox"/> Liberty Plan <sup>SM</sup> <input type="checkbox"/> Liberty Plan <sup>SM</sup> Direct <input type="checkbox"/> Oxford <sup>SM</sup> HSA Direct <sup>SM</sup> <input type="checkbox"/> Oxford USA <sup>SM</sup>	

**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, dated and signed by you. Attach proof of disability.

1. <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Civil Union Partner		2. Child		3. Child		4. Child	
<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Other <input type="checkbox"/> Continue <input type="checkbox"/> Continue CU Partner (NUSGC)		<input type="checkbox"/> Full-Time Student <input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Other <input type="checkbox"/> Continue		<input type="checkbox"/> Full-Time Student <input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Other <input type="checkbox"/> Continue		<input type="checkbox"/> Full-Time Student <input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Other <input type="checkbox"/> Continue	
Name (last, first, MI)		Name (last, first, MI)		Name (last, first, MI)		Name (last, first, MI)	
L: _____		L: _____		L: _____		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):	
<input type="checkbox"/> Male <input type="checkbox"/> Female / <input type="checkbox"/> Disabled		<input type="checkbox"/> Male <input type="checkbox"/> Female / <input type="checkbox"/> Disabled		<input type="checkbox"/> Male <input type="checkbox"/> Female / <input type="checkbox"/> Disabled		<input type="checkbox"/> Male <input type="checkbox"/> Female / <input type="checkbox"/> Disabled	
Social Security Number:		Social Security Number:		Social Security Number:		Social Security Number:	
Other Health Coverage		Other Health Coverage		Other Health Coverage		Other Health Coverage	
<input type="checkbox"/> Yes <input type="checkbox"/> No If yes: _____ Payer Name: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No If yes: _____ Payer Name: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No If yes: _____ Payer Name: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No If yes: _____ Payer Name: _____	
Policy #: _____		Policy #: _____		Policy #: _____		Policy #: _____	
Medicare ID #: _____		Medicare ID #: _____		Medicare ID #: _____		Medicare ID #: _____	
Previous Coverage:		Previous Coverage:		Previous Coverage:		Previous Coverage:	
<input type="checkbox"/> Yes <input type="checkbox"/> No If yes: _____ Effective: ____/____/____ Termination: ____/____/____ Payer Name: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No If yes: _____ Effective: ____/____/____ Termination: ____/____/____ Payer Name: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No If yes: _____ Effective: ____/____/____ Termination: ____/____/____ Payer Name: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No If yes: _____ Effective: ____/____/____ Termination: ____/____/____ Payer Name: _____	
Policy #: _____		Policy #: _____		Policy #: _____		Policy #: _____	

Continue on next page

Continue from previous page

1. Spouse, Domestic Partner, Civil Union Partner	2. Child	3. Child	4. Child
Other Rx Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: Payer Name: _____	Other Rx Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: Payer Name: _____	Other Rx Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: Payer Name: _____	Other Rx Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: Payer Name: _____
Policy #: Medicare ID #: _____	Policy #: Medicare ID #: _____	Policy #: Medicare ID #: _____	Policy #: Medicare ID #: _____
Primary Care Provider: Provider ID #: _____	Primary Care Provider: Provider ID #: _____	Primary Care Provider: Provider ID #: _____	Primary Care Provider: Provider ID #: _____
Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No Ob/Gyn Office Provider ID #: _____	Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No Ob/Gyn Office Provider ID #: _____	Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No Ob/Gyn Office Provider ID #: _____	Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No Ob/Gyn Office Provider ID #: _____
Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No Dentist Office Provider ID #: _____	Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No Dentist Office Provider ID #: _____	Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No Dentist Office Provider ID #: _____	Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No Dentist Office Provider ID #: _____
Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, complete Section E1	Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No If last name is different from Employee's, please explain: _____	Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No If last name is different from Employee's, please explain: _____	Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No If last name is different from Employee's, please explain: _____
Home or billing addresses same as Employee? <input type="checkbox"/> Yes <input type="checkbox"/> No If NO, complete Section E2	Living with Employee? <input type="checkbox"/> Yes <input type="checkbox"/> No If NO, complete Section F	Living with Employee? <input type="checkbox"/> Yes <input type="checkbox"/> No If NO, complete Section F	Living with Employee? <input type="checkbox"/> Yes <input type="checkbox"/> No If NO, complete Section F

<p><b>E. Additional Spouse/Civil Union Partner/Domestic Partner Information – To be completed by Employee. If not applicable, please mark as "NA."</b></p>	
<p>1. Employer Name: _____  Employer Address: _____  City, State, Zip Code: _____  Employer Phone: ( ) _____</p>	<p>2b. Please explain why the address is different:  _____  _____</p>
<p><b>F. Additional Child Information – To be completed by 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, dated and signed by you.</b></p>	
<p>2a.  Street/Apt: _____  City, State, Zip Code: _____</p>	<p>Name(s): _____  Street/Apt: _____  Street/Apt: _____  City, State, Zip Code: _____  Reason: _____</p>
<p><b>G. Additional Information for Dependent Under 31 Continuation Elections – Provide information below about children listed in Section D for whom a Dependent Under 31 continuation election is being made.</b></p>	
<p>This Continuation Election is being made:  <input type="checkbox"/> During Continuous Open Enrollment for Dependent Under 31 elections  <input type="checkbox"/> Within 30 days prior to the attainment of the limiting age (when the Dependent will become an Over-Age Child)</p>	
<p><b>H. Race/Ethnicity – to be completed by the Employee, at his/her option. NOTE: your response is appreciated but NOT required!</b></p>	
<p>Choose a category that most closely describes you:  <input type="checkbox"/> American Indian or Alaskan Native    <input type="checkbox"/> Black, not of Hispanic origin    <input type="checkbox"/> Hispanic  <input type="checkbox"/> Asian or Pacific Islander    <input type="checkbox"/> White, not of Hispanic origin</p>	
<p><b>I. Employee Signature</b></p>	<p>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.</p> <p>Signature: _____ Date: _____</p>
<p><b>J. Over-Age Child's Signature</b></p>	<p>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.</p> <p>Signature: _____ Date: _____</p>
<p><b>K. Employer Verification</b></p>	<p>The requested activity is believed eligible and is approved by the Employer.</p> <p>Employer Representative: _____ Date: _____</p> <p>Representative's Title: _____</p>