


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

| | | | |
|--|--|---------------------|-------------------------|
|  | 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 29142, Hot Springs, AR 71903 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 | <input type="checkbox"/> Enrollment of a new Subscriber | ____/____/____ | Date of Hire: ____/____/____ |
| | <input type="checkbox"/> Add Spouse | ____/____/____ | |
| | <input type="checkbox"/> Add 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 <i>(and complete section A 4)</i> | ____/____/____ | |
| 2. REMOVE | <input type="checkbox"/> Employee Withdrawal/Termination | ____/____/____ | |
| | <input type="checkbox"/> Remove Spouse | ____/____/____ | |
| | <input type="checkbox"/> Remove 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 | ____/____/____ | |
| 3. OTHER CHANGE | <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 | ____/____/____ | |
| 4. COVERAGE CONTINUATION | <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: ____/____/____ <i>*Attach proof of disability.</i> | <input type="checkbox"/> For Spouse/Civil Union Partner*/Domestic 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: ____/____/____ <i>*Civil union partners are eligible to make an election pursuant to NJSGC, if applicable.</i> | <input type="checkbox"/> For Dependent or Over-age Child <input type="checkbox"/> COBRA/NJSGC Length of Continuation (in months): <input type="checkbox"/> 18 <input type="checkbox"/> 36 Loss of Coverage: ____/____/____ Qualifying Event #: _____** Date: ____/____/____ <input type="checkbox"/> 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): _____ | <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Street/Apt: _____ Street/Apt: _____ City: _____ State: _____ Zip Code: _____ Preferred Phone: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work _____ Alternate Phone: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> 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 | <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> | | |
| | Primary Name: _____ | Provider #: _____ | Current Patient: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Ob/Gyn Name: _____ | Provider #: _____ | Current Patient: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Other Health Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| If yes: Payer Name: _____ Policy #: _____ | | | |
| Medicare ID#, if any: _____ | | | |

C. Plan Option - To be completed by the Employee

| | | | | |
|------------|---|---|---|--|
| OHI | <input type="checkbox"/> EPO Gated (Freedom Network) | <input type="checkbox"/> EPO Non-gated (Freedom Network) | <input type="checkbox"/> EPO HSA (Liberty Network) | <input type="checkbox"/> PPO Non-gated (Freedom Network) |
| | <input type="checkbox"/> EPO Gated (Liberty Network) | <input type="checkbox"/> EPO Non-gated (Liberty Network) | <input type="checkbox"/> EPO HSA (Garden State/Metro) | <input type="checkbox"/> PPO Non-gated (Liberty Network) |
| | <input type="checkbox"/> EPO Gated (Garden State/Metro) | <input type="checkbox"/> EPO Non-gated (Garden State/Metro) | <input type="checkbox"/> PPO HSA (Freedom Network) | <input type="checkbox"/> Other Plan _____ |
| | <input type="checkbox"/> PPO HSA (Liberty Network) | | | |
| OHP | <input type="checkbox"/> Silver HMO (Liberty Network) | <input type="checkbox"/> 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. <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner (DP) <input type="checkbox"/> Civil Union (CU) Partner | 2. Child | 3. Child | 4. Child |
|--|--|--|--|
| <input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Other <input type="checkbox"/> Continue Spouse <input type="checkbox"/> Continue Civil Union Partner (NJSGC) <input type="checkbox"/> Continue Domestic Partner (NJSGC) | <input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Other <input type="checkbox"/> Continue | <input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Other <input type="checkbox"/> Continue | <input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Other <input type="checkbox"/> Continue |
| Name (last, first, MI) L: _____ F: _____ MI: _____ | Name (last, first, MI) L: _____ F: _____ MI: _____ | Name (last, first, MI) L: _____ F: _____ MI: _____ | Name (last, first, MI) L: _____ F: _____ 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: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: Payer Name: _____ Policy#: _____ Medicare ID#: _____ | Other Health Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: Payer Name: _____ Policy#: _____ Medicare ID#: _____ | Other Health Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: Payer Name: _____ Policy#: _____ Medicare ID#: _____ | Other Health Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: Payer Name: _____ Policy#: _____ Medicare ID#: _____ |
| Primary Care Provider: Name: _____ Provider ID#: _____ Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No | Primary Care Provider: Name: _____ Provider ID#: _____ Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No | Primary Care Provider: Name: _____ Provider ID#: _____ Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No | Primary Care Provider: Name: _____ Provider ID#: _____ Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| OB/Gyn: Name: _____ Provider ID#: _____ Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No | OB/Gyn: Name: _____ Provider ID#: _____ Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No | OB/Gyn: Name: _____ Provider ID#: _____ Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No | OB/Gyn: Name: _____ 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 | 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? <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 |

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: _____ | 2b. | Please explain why the address is different: _____ _____ _____ |
| | Street/Apt: _____ | | |
| | City, State, Zip Code: _____ | | |

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): _____ | Name(s): _____ |
| Street/Apt: _____ | Street/Apt: _____ |
| Street/Apt: _____ | Street/Apt: _____ |
| City, State, Zip Code: _____ | City, State, Zip Code: _____ |
| Reason: _____ | 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.
- If 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.