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

Oxford Health Insurance, Inc.
**Mailing Address**: P.O. Box 29142, Hot Springs, AR 71903  1-800-444-6222  www.oxfordhealth.com

## 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 J 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 Plans, Inc., or any 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 | Effective Date/ Date of Event | Date of Hire/Reason for Change |
|---|---|---|---|
| 1. ADD | ☐ Enrollment of a new Subscriber | ____/____/____ | Date of Hire: ____/____/____ |
| | ☐ Add Spouse | ____/____/____ | ________________ |
| | ☐ 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 | ____/____/____ | ________________ |
| | ☐ 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/ Dentist | ____/____/____ | ________________ |

| | | | |
|---|---|---|---|
| 4. COVERAGE CONTINUATION | ☐ For Employee<br>☐ Total Disability*<br>☐ COBRA/NJSGC<br>Length of Continuation (in months):<br>☐ 18 ☐ 29<br>Date of Loss of Coverage: ___/___/___<br>Qualifying Event #: ______________**<br>Date of Qualifying Event: ___/___/___<br><br>**Attach proof of disability*<br>*** Qualifying event #s: see list in Instructions.* | ☐ For Spouse/Civil Union Partner*<br>Length of Continuation (in months):<br>☐ 18 ☐ 36<br>Date of Loss of Coverage: ___/___/___<br>Qualifying Event #: ______________**<br>Date of Qualifying Event: ___/___/___<br><br>**Civil union partners are eligible to make an election pursuant to NJSGC, if applicable.* | ☐ For Dependent or Over-age Child<br>☐ COBRA/NJSGC<br>Length of Continuation (in months):<br>☐ 18 ☐ 36<br>Loss of Coverage: ___/___/___<br>Qualifying Event #:______________**<br>Date: ___/___/___<br>☐ Dependent Under 31<br>Qualifying Event #:______________** |

| **B. Employee Information – to be completed by the Employee** | Name (Last, First, MI): | SSN: |
|---|---|---|

| | | |
|---|---|---|
| **Home** | Street/Apt:__________<br>City:__________ State:_____ Zip Code: __________ | Birthdate (mm/dd/yyyy): ☐ Male ☐ Female<br>Phone: (_____)__________ |
| **Work** | Employer Name:__________<br>Address:__________<br>City:__________ State:_____ Zip Code: __________ | Phone: (_____)__________<br>Employment Date: _____/_____/_____<br>Hours worked per week:_________ |
| **Activity** | ☐ Add ☐ Remove ☐ Continuation ☐ Other Change *If a name change, indicate prior name:* | |
| | Primary Name__________ Provider ID #: | Current Patient: ☐ Yes ☐ No |
| | Ob/Gyn Name__________ Provider ID #: | Current Patient: ☐ Yes ☐ No |
| | Dentist Name __________ Provider ID #: | Current Patient: ☐ Yes ☐ No |

| | |
|---|---|
| Other Health Coverage? ☐ Yes ☐ No *If yes:*<br>Payer Name: __________<br>Policy #: __________<br>Medicare ID#, if any: | Other Rx Coverage? ☐ Yes ☐ No *If yes:*<br>Payer Name:__________<br>Policy #: __________<br>Medicare ID#, if any: |
| Previous Coverage? ☐ Yes ☐ No<br>*If Yes:*<br>Effective date: _____/_____/_____ Termination date: _____/_____/_____ | Payer Name:__________<br>Policy #:__________ |

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

Small Group:
- ☐ Freedom Plan®
- ☐ Freedom Plan® Direct℠
- ☐ Oxford MyPlan℠
- ☐ Liberty Plan℠
- ☐ Liberty Plan℠ Direct
- ☐ Oxford® HSA Direct℠
- ☐ Oxford USA℠

**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. ☐Spouse ☐ Domestic Partner ☐Civil Union Partner** | **2. Child** | **3. Child** | **4. Child** |
|---|---|---|---|
| ☐Add ☐ Remove<br>☐Other ☐Continue Spouse<br>☐Continue CU Partner (NJSGC) | ☐ Add ☐ Remove<br>☐ Other ☐ Continue | ☐ Add ☐ Remove<br>☐Other ☐ Continue | ☐ Add ☐ Remove<br>☐Other ☐ Continue |
| Name (last, first, MI)<br>L:______________<br>F:______________<br>MI:______________ | Name (last, first, MI)<br>L:______________<br>F:______________<br>MI:______________ | Name (last, first, MI)<br>L:______________<br>F:______________<br>MI:______________ | Name (last, first, MI)<br>L:______________<br>F:______________<br>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<br>☐ Yes ☐ No<br>*If yes:*<br>Payer Name:<br>______________<br>Policy #: ______________<br>Medicare ID #:______________ | Other Health Coverage<br>☐ Yes ☐ No<br>*If yes:*<br>Payer Name:<br>______________<br>Policy #: ______________<br>Medicare ID #:______________ | Other Health Coverage<br>☐ Yes ☐ No<br>*If yes:*<br>Payer Name:<br>______________<br>Policy #: ______________<br>Medicare ID #:______________ | Other Health Coverage<br>☐ Yes ☐ No<br>*If yes:*<br>Payer Name:<br>______________<br>Policy #: ______________<br>Medicare ID #:______________ |
| Previous Coverage:<br>☐ Yes ☐ No<br>*If yes:*<br>Effective:___/___/___<br>Termination: ___/___/___<br>Payer Name:<br>______________<br>Policy #: ______________ | Previous Coverage:<br>☐ Yes ☐ No<br>*If yes:*<br>Effective:___/___/___<br>Termination: ___/___/___<br>Payer Name:<br>______________<br>Policy #: ______________ | Previous Coverage:<br>☐ Yes ☐ No<br>*If yes:*<br>Effective:___/___/___<br>Termination: ___/___/___<br>Payer Name:<br>______________<br>Policy #: ______________ | Previous Coverage:<br>☐ Yes ☐ No<br>*If yes:*<br>Effective:___/___/___<br>Termination: ___/___/___<br>Payer Name:<br>______________<br>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:<br>☐ Yes ☐ No<br>*If yes:*<br>Payer Name:<br>____________________<br>Policy #: ________________<br>Medicare ID #:________________ | Other Rx Coverage:<br>☐ Yes ☐ No<br>*If yes:*<br>Payer Name:<br>____________________<br>Policy #: ________________<br>Medicare ID #:________________ | Other Rx Coverage:<br>☐ Yes ☐ No<br>*If yes:*<br>Payer Name:<br>____________________<br>Policy #: ________________<br>Medicare ID #:________________ | Other Rx Coverage:<br>☐ Yes ☐ No<br>*If yes:*<br>Payer Name:<br>____________________<br>Policy #: ________________<br>Medicare ID #:________________ |
| Primary Care Provider:<br>Provider ID #:________________<br>Current Patient? ☐ Yes ☐ No | Primary Care Provider:<br>Provider ID #:________________<br>Current Patient? ☐ Yes ☐ No | Primary Care Provider:<br>Provider ID #:________________<br>Current Patient? ☐ Yes ☐ No | Primary Care Provider:<br>Provider ID #:________________<br>Current Patient? ☐ Yes ☐ No |
| Ob/Gyn Office<br>Provider ID #:________________<br>Current Patient? ☐ Yes ☐ No | Ob/Gyn Office<br>Provider ID #:________________<br>Current Patient? ☐ Yes ☐ No | Ob/Gyn Office<br>Provider ID #:________________<br>Current Patient? ☐ Yes ☐ No | Ob/Gyn Office<br>Provider ID #:________________<br>Current Patient? ☐ Yes ☐No |
| Dentist Office<br>Provider ID #:________________<br>Current Patient? ☐ Yes ☐ No | Dentist Office<br>Provider ID #:________________<br>Current Patient? ☐ Yes ☐ No | Dentist Office<br>Provider ID #:________________<br>Current Patient? ☐ Yes ☐ No | Dentist Office<br>Provider ID #:________________<br>Current Patient? ☐ Yes ☐ No |
| Employed? ☐ Yes ☐ No<br>*If YES, complete Section E1* | If last name is different from Employee's, please explain:<br>____________________<br>____________________ | If last name is different from Employee's, please explain:<br>____________________<br>____________________ | If last name is different from Employee's, please explain:<br>____________________<br>____________________ |
| Home or billing addresses same as Employee? ☐ Yes ☐ No<br>*If NO, complete Section E2* | Living with Employee?<br>☐ Yes ☐ No<br>*If NO, complete Section F* | Living with Employee?<br>☐ Yes ☐ No<br>*If NO, complete Section F* | Living with Employee?<br>☐ Yes ☐ No<br>*If NO, complete Section F* |

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

1. Employer Name:______________________________
   Employer Address:______________________________
   City, State, Zip Code:______________________________
   Employer Phone: (     )

2a. Street/Apt:______________________________
City, State, Zip Code:______________________________

2b. Please explain why the address is different:
______________________________
______________________________

**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.*

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
- ☐ Asian or Pacific Islander
- ☐ Black, not of Hispanic origin
- ☐ White, not of Hispanic origin
- ☐ Hispanic

**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: ______________________________