


# 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
<b>1. ADD</b>	<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>	____/____/____	
<b>2. REMOVE</b>	<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	____/____/____	
<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	____/____/____	
<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: ____/____/____ <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
<b>HOME</b> 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: _____			
<b>WORK</b> 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)**

<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>		
	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?  Yes  No  
 If yes: Payer Name: \_\_\_\_\_ Policy #: \_\_\_\_\_  
 Medicare ID#, if any: \_\_\_\_\_

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

<b>OHI</b>	<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 _____
<b>OHP</b>	<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 <i>If Yes, complete Section E1</i>	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 <i>If No, complete Section E2</i>	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".*

<b>1.</b>	Employer Name: _____		
	Employer Address: _____		
	City, State, Zip Code: _____		Employer Phone: _____
<b>2a.</b>	Street/Apt: _____	<b>2b.</b>	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.