



New York Member Enrollment Form - OHI	arollm	ent Fo	orm - OHI		UnitedHealthcare*
MAILING ADDRESS: P. O. Box 29142, Hot Springs, AR 71903 • 1-800-444-6222 • www.oxfordhealth.com	ngs, AR 719	03 • 1-800-44	4-6222 • www.oxfordheali		Oxford
A. Group Information (To be completed by the employer)	er)		Please print neatly using blac	k or blue ballpoint pen • ALL	Please print neatly using black or blue ballpoint pen • ALL DATES MUST BE: MM/DD/YYYY
Group Number Group Name Group Name Group Name	Plan CSP	Billing Group Date of Hire	Date of Hire	Effective Date / /	Occupation
On I save of Absence Retired	COBRA/Your	ng Adult/SC Qualif	COBRA/Young Adult/SC Qualifying Event Date	Employer Signature	Date

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Date	mature	Employee's/Young Adult's Signature		Email Address:
	Cell 🗆 Work	Alternate Phone: ☐ Home ☐ C	ZIP Code	City State
	Cell Work	Preferred Phone: Home	(Apt #)	Employee's/Young Adult's Address
care through our Oxford affiliated primary ca or out-of-network health insurance coverag ng any materially false information, of to exceed five thousand dollars ar	-network benefits, land any enrolled dependents must seek cars to not adhere to these requirements, I will be eligible only for o attending for insurance or statement of claim containing trime and shall also be subject to a civil penalty not talled member of my family for whom information is requested.	erstand that, inorder to receive in-network ber d. I further understand that if I do not adhere other person files an application for it t insurance act, which is a crime and s ords concerning me or any enrolled member	the Oxford Health Insurance Certificate. I und ral from the primary care physician if require to defraud any insurance company or material thereto, commits a fraudulent rovider or insurer to furnish Oxford any reco	Innderstand that my enrollments and benefits are in accordance with those described in the Oxford Health Insurance Certificate. I understand that, in order to receive in-network benefits, I and any enrolled dependents must seek care through our Oxford affiliated primary care physician or through an Oxford-affiliated specialist physician with an authorized referral from the primary care physician if required. I further understand that if I do not adhere to these requirements, I will be eligible only for out-of-network health insurance coverage under the terms of the Certificate. Any person who knowlingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars are the stated value of the claim for each such violation. I authorize any health provider or insurer to furnish Oxford any records concerning me or any enrolled member of my family for whom information is requested.
				Policy Number: Medical Carrier: Policy Holder: Effective Date:
BIN: PCN:	BIN: PCN:	BIN: PCN:	BIN: PCN:	Pharmacy Same for all Same for all Carrier: Policy Number: Policy Holder: Group Number:
□ Part A / / □ Part B / / □ Part D / /	□ Part A / / □ Part B / / □ Part D / /	□ Part A / / □ Part B / / / □ Part D / /	□ Part A / / □ Part B / / □ Part D / /	Check appropriate Medicare Coverage box and list effective date:
Child	Child	Spouse	Employee/Subscriber	C. Coordination of Benefits
☐ Young Adult	☐ Young Adult	☐ Domestic Partner		Check all that apply:
Y(Yes	□Yes	Tes	Primary Care Physician (PCP) ID Number: PCP Name: (If an existing patient of PCP, check "Yes".)
□M □F	□M □F	OM OF	□M □F	Gender: (Check appropriate boxes.)
1 1		1 1	1 1	Date of Birth: (MM/DD/YYYY)
				First Name, Middle Initial:
			į.	Last Name:
37	(Social Security Number:
Child	Child	Spouse	Employee/Subscriber	B. Applicant Details (To be completed by the employee)
Date 6/22/18	X Supplemental Sign Bridge	fying Event Date	COBRA/Young Adult/SC Qualifying Event	☐ On Leave of Absence ☐ Retired ☐ Unicn Employee
Occupation	Effective Date	Date of Hire	Plan CSP Billing Group	Group Number Group Name Group Name GROWN HS.
ALL DATES MUST BE. MM/DD/TTT	ng black of blue ballpoint pell - ALL DA	Please print heatly using brace		A. Group information (16 be completed by the employer