PLAN :

STATUS:

New York Member Enrollment Form – OHI

UnitedHealthcare®
Oxford

MAILING ADDRESS: P. O. Box 29142, Hot Springs, AR 71903 • 1-800-444-6222 • *www.oxfordhealth.com*

A. Group Information (To be completed by the **employer**)				Please print neatly using black or blue ballpoint pen • ALL DATES MUST BE: MM/DD/YYYY
Group Number / Group Name: CRISTO REY BROOKLYN H.S.	Plan CSP / Billing Group	Date of Hire / /	Effective Date / /	Occupation
☐ On Leave of Absence ☐ Retired ☐ Union Employee	COBRA/Young Adult/SC Qualifying Event	Event Date / /	Employer Signature X	Date 6/22/18

B. Applicant Details (To be completed by the **employee**)	Employee/Subscriber	Spouse	Child	Child
Social Security Number:				
Last Name:				
First Name, Middle Initial:				
Date of Birth: (MM/DD/YYYY)	/ /	/ /	/ /	/ /
Gender: (Check appropriate boxes.)	☐ M ☐ F	☐ M ☐ F	☐ M ☐ F	☐ M ☐ F
Primary Care Physician (PCP) ID Number: PCP Name: (If an existing patient of PCP, check "Yes".)	☐ Yes	☐ Yes	☐ Yes	☐ Yes
Check all that apply:		☐ Domestic Partner	☐ Young Adult	☐ Young Adult

C. Coordination of Benefits		Employee/Subscriber	Spouse	Child	Child
Medicare Coverage	Check appropriate box and list effective date:	☐ Part A / / ☐ Part B / / ☐ Part D / /	☐ Part A / / ☐ Part B / / ☐ Part D / /	☐ Part A / / ☐ Part B / / ☐ Part D / /	☐ Part A / / ☐ Part B / / ☐ Part D / /
Pharmacy ☐ Same for all Effective Date: / /	Policy Number: Carrier: Policy Holder: Group Number:	BIN: PCN:	BIN: PCN:	BIN: PCN:	BIN: PCN:
Medical ☐ Same for all	Policy Number: Carrier: Policy Holder: Effective Date:	/ /	/ /	/ /	/ /

I understand 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 knowingly 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, or 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 and 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.

Employee's/Young Adult's Address	**(Apt #)**	**Preferred Phone:** ☐ **Home** ☐ **Cell** ☐ **Work**
City / **State** / **ZIP Code**		**Alternate Phone:** ☐ **Home** ☐ **Cell** ☐ **Work**
Email Address: @CRISTOREYBROOKLYN.ORG		**Employee's/Young Adult's Signature** X **Date** / /