

A. Employer/Employee Information (To be completed by the employer)			
Group ID Number:	Group Name:		
Employee Insurance ID Number:	Employer Signature	Date	
Employee Name:	X	/ /	
B. Transaction	Effective Date	Required Information	
<input type="checkbox"/> Termination	/ /	Who: <input type="checkbox"/> Employee <input type="checkbox"/> Spouse/Partner <input type="checkbox"/> Dependent(s) <input type="checkbox"/> NY Young Adult	Reason: <input type="checkbox"/> Left Employer <input type="checkbox"/> Discontinue COBRA <input type="checkbox"/> Switched Plans <input type="checkbox"/> Discontinue NY Young Adult <input type="checkbox"/> Other:
<input type="checkbox"/> Change Address changes can be done online or by calling Oxford.	/ /	Who: Last Name: First Name:	Effective Date: / / Date of Birth: / / Other: SS#: Middle Initial: Gender: <input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/> COBRA or State Continuation	/ /	Who : <input type="checkbox"/> Employee <input type="checkbox"/> Spouse/Partner* <input type="checkbox"/> Dependent(s)*	Reason: <input type="checkbox"/> Left Employer <input type="checkbox"/> Hours Reduction <input type="checkbox"/> Other: Date of Event: / /
<small>*A New Member Enrollment Form is required for: Loss of Dependent Status, Divorce/Separation, or Death of Subscriber.</small>			
<input type="checkbox"/> Transfer Complete entire section	/ /	New Plan CSP: New Billing Group: Reason:	Retiree Drug Subsidy: <input type="checkbox"/> Yes <input type="checkbox"/> No Actively Working: <input type="checkbox"/> Yes <input type="checkbox"/> No Enrolled in Medicare Part: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> D
<input type="checkbox"/> Addition Complete WHO, REASON and SECTION C below	/ /	Who : <input type="checkbox"/> Spouse <input type="checkbox"/> Civil Union <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Dependent(s)	Reason: <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Loss of Coverage <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Other: <input type="checkbox"/> Date of Marriage <input type="checkbox"/> Date of Civil Union <input type="checkbox"/> Date of Partnership
C. Additional Information			
	Spouse	Dependent	Dependent
Social Security Number:			
Last Name:			
First Name, Middle Initial:			
Date of Birth: (MM/DD/YYYY)	/ /	/ /	/ /
Gender and Disability Status:	<input type="checkbox"/> M <input type="checkbox"/> F / <input type="checkbox"/> Disabled	<input type="checkbox"/> M <input type="checkbox"/> F / <input type="checkbox"/> Disabled	<input type="checkbox"/> M <input type="checkbox"/> F / <input type="checkbox"/> Disabled
Primary Care Physician (PCP) ID Number: PCP Name: (If an existing patient, check "Yes".)	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Check all that apply:	<input type="checkbox"/> Actively employed <input type="checkbox"/> Not actively employed	<input type="checkbox"/> Full-time Student (Age 19 - 23)	<input type="checkbox"/> Full-time Student (Age 19 - 23)
Prior Carrier What coverage you had prior to this.	Policy Number: Carrier: From Date: / / Thru Date: / /		
D. Coordination of Benefits			
	Spouse	Dependent	Dependent
Medicare Check appropriate box and list effective date:	<input type="checkbox"/> Part A / / <input type="checkbox"/> Part B / / <input type="checkbox"/> Part D / /	<input type="checkbox"/> Part A / / <input type="checkbox"/> Part B / / <input type="checkbox"/> Part D / /	<input type="checkbox"/> Part A / / <input type="checkbox"/> Part B / / <input type="checkbox"/> Part D / /
Pharmacy <input type="checkbox"/> Same for all Effective Date: / /	Policy Number: Carrier: Policy Holder: Group Number: BIN: PCN:		
Medical <input type="checkbox"/> Same for all	Policy Number: Carrier: Policy Holder: Effective Date: / /		

ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR INSURANCE IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES

Employee Signature

Date

X

/ /