Oxford Health Plans®

Dental Enrollment Form

Oxford Health Plans, Inc.

Mailing Address: P.O. Box 7085, Bridgeport, CT 06601-7085 • **Local Address:** 48 Monroe Turnpike, Trumbull, CT 06611 • 800-444-6222 • www.oxfordhealth.com

Plan Type: ❑ **Premium** ❑ **Enhanced**

To Be Completed By Employer (Please Print)

GROUP NAME	OXFORD GROUP ID NUMBER	EMPLOYEE'S EFFECTIVE DATE OF COVERAGE
		/ /

EMPLOYER SIGNATURE

X

To Be Completed By EMPLOYEE (Please Print)

LAST NAME | FIRST NAME & MI

STREET ADDRESS | APT. NO. | HOME PHONE | BUSINESS PHONE

CITY | STATE | ZIP | SOCIAL SECURITY NUMBER | ❑ MALE ❑ FEMALE | DATE OF BIRTH MO. DAY YEAR

OXFORD PRIMARY CARE DENTIST NAME* | PROVIDER CODE

Dependent Information (Please Print)

SPOUSE'S LAST NAME | FIRST NAME | MI | ❑ MALE ❑ FEMALE

OXFORD PRIMARY CARE DENTIST NAME* | PROVIDER CODE | SOCIAL SECURITY NUMBER | DATE OF BIRTH MO. DAY YEAR

ELIGIBLE CHILD'S LAST NAME | FIRST NAME | MI | ❑ MALE ❑ FEMALE

OXFORD PRIMARY CARE DENTIST NAME* | PROVIDER CODE | SOCIAL SECURITY NUMBER | DATE OF BIRTH MO. DAY YEAR

ELIGIBLE CHILD'S LAST NAME | FIRST NAME | MI | ❑ MALE ❑ FEMALE

OXFORD PRIMARY CARE DENTIST NAME* | PROVIDER CODE | SOCIAL SECURITY NUMBER | DATE OF BIRTH MO. DAY YEAR

ELIGIBLE CHILD'S LAST NAME | FIRST NAME | MI | ❑ MALE ❑ FEMALE

OXFORD PRIMARY CARE DENTIST NAME* | PROVIDER CODE | SOCIAL SECURITY NUMBER | DATE OF BIRTH MO. DAY YEAR

*** You must select a General Practice (GP) Dentist from Oxford's Roster of Participating Dentists for each family member.**

Do you or your spouse have any other Group Dental Coverage in addition to Oxford? ❑ Yes ❑ No **If yes, please give:**

Name of Group Administrator/Plan _____ Policy # _____

I understand that my enrollment and benefits are in accordance with those described in the Oxford Health Plans Dental Rider. I agree to choose a participating Oxford General Practice Dentist for my primary dental care and to seek any necessary specialty care through Oxford participating Dental Specialists. I authorize any provider or insurer to furnish Oxford Health Plans any records concerning me or any member of my family for whom information is required. A photographic copy of this authorization shall be as valid as the original. I agree to submit any disputes with Oxford in accordance with the Oxford Health Plans Contract. I authorize my employer to deduct from my wages the amount required (if any) to cover my contribution for coverage. I certify that I and any of my dependents have no other dental insurance other than that listed above. I certify that all the above information is correct.

X

EMPLOYEE SIGNATURE DATE