



Oxford Health Plans[®]

Addition/Termination/Change Form

Mailing Address: P.O. Box 7085 Bridgeport, CT 06601 • 800-444-6222 **Corporate Address:** 48 Monroe Turnpike, Trumbull CT 06611 • www.oxfordhealth.com
 For your convenience, this form can be completed online at www.oxfordhealth.com/your-account

GENERAL INFORMATION			
EMPLOYER	OXFORD GROUP ID NUMBER	CONTRACT SPECIFIC PACKAGE (CSP)	BILLING GROUP (BG)
<input checked="" type="checkbox"/> EMPLOYER SIGNATURE	DATE	OXFORD MEMBER ID NUMBER	OXFORD MEMBER SOCIAL SECURITY NUMBER

LAST NAME											FIRST NAME & MI										
STREET ADDRESS																					
CITY										STATE	ZIP	LANGUAGE SPOKEN, IF OTHER THAN ENGLISH									
<input checked="" type="checkbox"/> EMPLOYEE SIGNATURE																					

HEALTHCARE															
<input type="checkbox"/> ADD SPOUSE TO PLAN EFFECTIVE (DATE)		REASON FOR ADDITION				<input type="checkbox"/> NEWLY MARRIED - DATE OF MARRIAGE / /		<input type="checkbox"/> OPEN ENROLLMENT		<input type="checkbox"/> OTHER (PLEASE SPECIFY)					
SPOUSE'S LAST NAME				FIRST NAME AND MI				BIRTH DATE		SOCIAL SECURITY NUMBER		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE			
WILL SPOUSE HAVE ANY OTHER HEALTH COVERAGE (INCL. MEDICARE)? <input type="checkbox"/> YES <input type="checkbox"/> NO				IF YES, NAME OF CARRIER				POLICY NUMBER		COVERAGE DATE(S)		/ / TO / /			
SPOUSE'S OXFORD PRIMARY CARE PHYSICIAN				OXFORD CODE				OXFORD OB/GYN PROVIDER (IF FEMALE)		OXFORD OB/GYN CODE					
<input type="checkbox"/> ADD DEPENDENT TO PLAN EFFECTIVE (DATE)		REASON FOR ADDITION				<input type="checkbox"/> NEWBORN		<input type="checkbox"/> OPEN ENROLLMENT		<input type="checkbox"/> OTHER (PLEASE SPECIFY)					
LAST NAME				FIRST NAME AND MI				BIRTH DATE		SOCIAL SECURITY NUMBER		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE			
WILL DEPENDENT HAVE ANY OTHER HEALTH COVERAGE (INCL. MEDICARE)? <input type="checkbox"/> YES <input type="checkbox"/> NO				IF YES, NAME OF CARRIER				POLICY NUMBER		COVERAGE DATE(S)		/ / TO / /			
DEPENDENT'S OXFORD PRIMARY CARE PHYSICIAN				OXFORD CODE				OXFORD OB/GYN PROVIDER (IF FEMALE)		OXFORD OB/GYN CODE					
<input type="checkbox"/> TERMINATE THE FOLLOWING INDIVIDUALS:															
<input type="checkbox"/> EMPLOYEE <input type="checkbox"/> SPOUSE ONLY <input type="checkbox"/> DEPENDENT(S) ONLY <input type="checkbox"/> SPOUSE AND DEPENDENT(S) ONLY <input type="checkbox"/> FAMILY															
LAST DATE OF COVERAGE				REASON FOR TERMINATION								<input type="checkbox"/> LEFT EMPLOYER <input type="checkbox"/> SWITCHED TO ANOTHER PLAN <input type="checkbox"/> DISCONTINUE COBRA <input type="checkbox"/> OTHER (PLEASE SPECIFY)			
<input type="checkbox"/> CHANGE EFFECTIVE (DATE)															
LAST NAME				FIRST NAME AND MI				ADDRESS							
TELEPHONE (WORK)				TELEPHONE (HOME)				CITY				STATE		ZIP	
OXFORD PRIMARY CARE PHYSICIAN				OXFORD CODE				OXFORD OB/GYN PROVIDER (IF FEMALE)		OXFORD OB/GYN CODE					
<input type="checkbox"/> CHANGE TO COBRA:															
<input type="checkbox"/> EMPLOYEE <input type="checkbox"/> EMPLOYEE AND SPOUSE <input type="checkbox"/> EMPLOYEE AND DEPENDENTS <input type="checkbox"/> SPOUSE ONLY <input type="checkbox"/> DEPENDENT(S) ONLY <input type="checkbox"/> SPOUSE AND DEPENDENT(S) ONLY <input type="checkbox"/> FAMILY															
QUALIFYING EVENT				DATE OF QUALIFYING EVENT / /				DATE COBRA EFFECTIVE				(IMPORTANT NOTE: THIS FORM IS FOR USE ONLY BY GROUPS IN WHICH OXFORD HEALTH PLANS IS NOT ADMINISTERING COBRA.)			
<input type="checkbox"/> TRANSFER MEMBER'S SUBGROUP ID				OXFORD MEMBER ID NUMBER				EFFECTIVE DATE		FROM		TO			
CONTRACT SPECIFIC PACKAGE (CSP)				BILLING GROUP (BG)				<input type="checkbox"/> OTHER		REASON					

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

<input checked="" type="checkbox"/>	
EMPLOYER SIGNATURE	DATE