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)
X 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
X EMPLOYEE SIGNATURE			

HEALTHCARE

❑ **ADD SPOUSE** TO PLAN EFFECTIVE (DATE) | REASON FOR ADDITION ❑ NEWLY MARRIED – DATE OF MARRIAGE / / ❑ OPEN ENROLLMENT ❑ OTHER (PLEASE SPECIFY)

SPOUSE'S LAST NAME	FIRST NAME AND MI	BIRTH DATE	SOCIAL SECURITY NUMBER	❑ MALE ❑ FEMALE
WILL SPOUSE HAVE ANY OTHER HEALTH COVERAGE (INCL. MEDICARE)? ❑ YES ❑ 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

❑ **ADD DEPENDENT** TO PLAN EFFECTIVE (DATE) | REASON FOR ADDITION ❑ NEWBORN ❑ OPEN ENROLLMENT ❑ OTHER (PLEASE SPECIFY)

LAST NAME	FIRST NAME AND MI	BIRTH DATE	SOCIAL SECURITY NUMBER	❑ MALE ❑ FEMALE
WILL DEPENDENT HAVE ANY OTHER HEALTH COVERAGE (INCL. MEDICARE)? ❑ YES ❑ 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

❑ **TERMINATE** THE FOLLOWING INDIVIDUALS: ❑ EMPLOYEE ❑ SPOUSE ONLY ❑ DEPENDENT(S) ONLY ❑ SPOUSE AND DEPENDENT(S) ONLY ❑ FAMILY

LAST DATE OF COVERAGE _____ | REASON FOR TERMINATION ❑ LEFT EMPLOYER ❑ SWITCHED TO ANOTHER PLAN ❑ DISCONTINUE COBRA ❑ OTHER (PLEASE SPECIFY)

❑ **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

❑ **CHANGE** TO COBRA: ❑ EMPLOYEE ❑ EMPLOYEE AND SPOUSE ❑ EMPLOYEE AND DEPENDENTS ❑ SPOUSE ONLY ❑ DEPENDENT(S) ONLY ❑ SPOUSE AND DEPENDENT(S) ONLY ❑ 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.)	
❑ **TRANSFER** MEMBER'S SUBGROUP ID	OXFORD MEMBER ID NUMBER	EFFECTIVE DATE FROM	TO
CONTRACT SPECIFIC PACKAGE (CSP)	BILLING GROUP (BG)	❑ **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.

X

EMPLOYER SIGNATURE DATE