Oxford Health Plans®

Oxford Health Insurance Inc.

Connecticut Member Enrollment Form - OHI

Mailing Address: P.O. Box 7085, Bridgeport, CT 06601 • 203-852-1442 • 800-444-6222 • www.oxfordhealth.com

Thank you for choosing Oxford Health Plans as the health plan for you and your family.

IMPORTANT!

In order to process the attached Member Enrollment form and begin coverage, all of the following information must be completed accurately and in its entirety:
INCOMPLETE FORMS WILL BE RETURNED.

By the Employer

- Group Number
- Contract Specific Package (CSP)
- Billing Group (BG)
- Date of Full-Time Employment
- Employer Signature
- Effective Date of Coverage

By the Employee

- Date of Marriage
- Date of Birth
- Social Security Numbers
- Primary Care Physician selections (not required for Freedom Plan Select and Oxford USA plans)
- Information on other coverage that you or your spouse may have
- Signature at the bottom of the form
- Mailing Address, including Zip Code

* Please complete the enclosed "Family Health Statement." when instructed by your Benefits Administrator.

Note: Please press down firmly when completing this form.

If you have any questions, please feel free to call our Member Service Department at 800-444-6222 or 203-852-1442. Thank you for your cooperation.

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Please do not write in this area, for Oxford use only.

To Be Completed By EMPLOYER (Please Print)

NAME OF GROUP (EMPLOYER) | GROUP NUMBER | CONTRACT SPECIFIC PACKAGE (CSP) | BILLING GROUP (BG)

EMPLOYEE'S EFFECTIVE DATE OF COVERAGE MO. DAY YEAR | IS INDIVIDUAL COVERED UNDER COBRA? ❑ YES ❑ NO IF YES, QUALIFYING EVENT | DATE OF QUALIFYING EVENT MO. DAY YEAR

DATE OF FULL-TIME EMPLOYMENT MO. DAY YEAR | AVERAGE NO. OF HOURS WORKED PER WEEK | EMPLOYEE OCCUPATION: ❑ EXECUTIVE ❑ MANAGEMENT ❑ NON-MANAGEMENT ❑ HOURLY ❑ OTHER (PLEASE SPECIFY) | EMPLOYEE CLASSIFICATION ❑ UNION ❑ NON-UNION

X EMPLOYER SIGNATURE | DATE

To Be Completed By EMPLOYEE (Please Print)

SOCIAL SECURITY NO. | LAST NAME

FIRST NAME | MI | BIRTH DATE MO. DAY YEAR | ❑ MALE ❑ FEMALE | HOME PHONE ( ) | BUSINESS PHONE ( )

STREET ADDRESS | APT. NO. | CITY | STATE | ZIP

WILL YOU HAVE ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD? ❑ YES ❑ NO IF YES, CARRIER NAME | NAME OF POLICY HOLDER | POLICY START DATE / /

OXFORD CODE OF PRIMARY CARE PHYSICIAN SELECTED | ARE YOU AN EXISTING PATIENT? ❑ YES ❑ NO | PRIOR HEALTH INSURANCE INFORMATION: CARRIER NAME

OXFORD CODE OF OB/GYN SELECTED (Female Members) | ARE YOU AN EXISTING PATIENT? ❑ YES ❑ NO | COVERAGE BEGIN DATE / / COVERAGE END DATE / /

EMPLOYEE'S Dependent Information (Please Print)

Please only complete for dependents who will be covered on your Oxford policy

SPOUSE'S SOCIAL SECURITY NUMBER | SPOUSE'S LAST NAME | SPOUSE'S FIRST NAME | MI

SPOUSE'S BIRTH DATE MO. DAY YEAR | ❑ MALE ❑ FEMALE | DATE OF MARRIAGE MO. DAY YEAR | SPOUSE'S EMPLOYER

WILL YOU HAVE ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD? ❑ YES ❑ NO IF YES, CARRIER NAME | NAME OF POLICY HOLDER | POLICY START DATE / /

OXFORD CODE OF PRIMARY CARE PHYSICIAN SELECTED | ARE YOU AN EXISTING PATIENT? ❑ YES ❑ NO | PRIOR HEALTH INSURANCE INFORMATION: CARRIER NAME

OXFORD CODE OF OB/GYN SELECTED (Female Members) | ARE YOU AN EXISTING PATIENT? ❑ YES ❑ NO | COVERAGE BEGIN DATE / / COVERAGE END DATE / /

ELIGIBLE CHILD'S SOCIAL SECURITY NO. | ELIGIBLE CHILD'S LAST NAME | ELIGIBLE CHILD'S FIRST NAME | MI | ❑ MALE ❑ FEMALE

ELIGIBLE CHILD'S BIRTH DATE MO. DAY YEAR | IS THIS DEPENDENT DISABLED? ❑ YES ❑ NO | WILL YOU HAVE ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD? ❑ NO ❑ YES IF YES, CARRIER NAME: | NAME OF POLICY HOLDER | POLICY START DATE / /

OXFORD CODE OF PRIMARY CARE PHYSICIAN SELECTED | ARE YOU AN EXISTING PATIENT? ❑ YES ❑ NO | PRIOR HEALTH INSURANCE INFORMATION: CARRIER NAME

OXFORD CODE OF OB/GYN SELECTED (Female Members) | ARE YOU AN EXISTING PATIENT? ❑ YES ❑ NO | COVERAGE BEGIN DATE / / COVERAGE END DATE / /

ELIGIBLE CHILD'S SOCIAL SECURITY NO. | ELIGIBLE CHILD'S LAST NAME | ELIGIBLE CHILD'S FIRST NAME | MI | ❑ MALE ❑ FEMALE

ELIGIBLE CHILD'S BIRTH DATE MO. DAY YEAR | IS THIS DEPENDENT DISABLED? ❑ YES ❑ NO | WILL YOU HAVE ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD? ❑ NO ❑ YES IF YES, CARRIER NAME: | NAME OF POLICY HOLDER | POLICY START DATE / /

OXFORD CODE OF PRIMARY CARE PHYSICIAN SELECTED | ARE YOU AN EXISTING PATIENT? ❑ YES ❑ NO | PRIOR HEALTH INSURANCE INFORMATION: CARRIER NAME

OXFORD CODE OF OB/GYN SELECTED (Female Members) | ARE YOU AN EXISTING PATIENT? ❑ YES ❑ NO | COVERAGE BEGIN DATE / / COVERAGE END DATE / /

ELIGIBLE CHILD'S SOCIAL SECURITY NO. | ELIGIBLE CHILD'S LAST NAME | ELIGIBLE CHILD'S FIRST NAME | MI | ❑ MALE ❑ FEMALE

ELIGIBLE CHILD'S BIRTH DATE MO. DAY YEAR | IS THIS DEPENDENT DISABLED? ❑ YES ❑ NO | WILL YOU HAVE ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD? ❑ NO ❑ YES IF YES, CARRIER NAME: | NAME OF POLICY HOLDER | POLICY START DATE / /

OXFORD CODE OF PRIMARY CARE PHYSICIAN SELECTED | ARE YOU AN EXISTING PATIENT? ❑ YES ❑ NO | PRIOR HEALTH INSURANCE INFORMATION: CARRIER NAME

OXFORD CODE OF OB/GYN SELECTED (Female Members) | ARE YOU AN EXISTING PATIENT? ❑ YES ❑ NO | COVERAGE BEGIN DATE / / COVERAGE END DATE / /

If you have additional dependents, please use another enrollment form to provide the necessary information.

In order to help us quickly process this form and avoid delays, please make sure all areas are properly filled out.

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. Covered services will be treated as Out-of-network benefits under the terms and conditions outlined in the Certificate.

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

X

EMPLOYEE/APPLICANT SIGNATURE DATE

Thank you for choosing an Oxford health care plan for your employees.

We want you to be aware of an important State of Connecticut legislation amendment regarding medical loss ratio. Public Act 09-46 changes the definition of the term and requires disclosure of medical loss ratio to insurance applicants.

As of October 1, 2009, health insurers are required to include a written notice of their medical loss ratio with each individual or group health insurance application for coverage, as reported in the last Consumer Report Card on Health Insurance Carriers in Connecticut.

Please share the following information with employees at the time of their application for Oxford coverage:

The medical loss ratio is defined as the ratio of incurred claims to earned premium for the prior calendar year for managed care plans issued in Connecticut. It limits claims to medical expenses for services and supplies provided to members, excluding expenses for stop loss coverage, reinsurance, member educational programs, and other cost containment programs or features. The medical loss ratio for Oxford Health Plans (CT) for calendar year 2008 is 81.48 percent. The medical loss ratio for Oxford Health Insurance, Inc. is 83.1 percent.

Going forward, our Web site at *www.oxfordhealth.com* will be updated annually with our most current medical loss ratio information.

If you have questions regarding this new Public Act, please contact Oxford Client Services.

Sincerely,

Oxford