A UnitedHealthcare Company

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 the Employer area of our web site

GENERAL INFORMATION

EMPLOYER	OXFORD GROUP ID NUMBER	CONTRACT SPECIFIC PACKAGE (CSP)	BILLING GROUP (BG)
X EMPLOYER SIGNATURE	DATE	OXFORD MEMBER ID 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