UnitedHealthcare® OXFORD®

Addition/Termination Change Form

P. O. Box 7085, Bridgeport CT 06601 ▪ 1-800-444-6222

Many transactions can be completed online at the employer area of our website *www.oxfordhealth.com*

Please print neatly using black or blue ballpoint pen

ALL DATES MUST BE: MM/DD/YYYY

A. Employer/Employee Information (To be completed by the employer)

Group ID Number:	Group Name:
Employee Insurance ID Number:	Employer Signature X — Date
Employee Name:	

B. Transaction	Effective Date	Required Information
☐ **Termination**		**Who:** ☐ Employee ☐ Spouse/Partner ☐ Dependent(s) ☐ NY Young Adult **Reason:** ☐ Left Employer ☐ Discontinue COBRA ☐ Switched Plans ☐ Discontinue NY Young Adult ☐ Other:
☐ **Change** Address changes can be done online or by calling Oxford.		Who: Last Name: First Name: Effective Date: Date of Birth: Other: SS#: Middle Intial: Gender: ☐ M ☐ F
☐ **COBRA or State Continuation**		**Who :** ☐ Employee ☐ Spouse/Partner* ☐ Dependent(s)* **Reason:** ☐ Left Employer ☐ Hours Reduction ☐ Other: Date of Event: *A **New Member Enrollment Form** is required for: Loss of Dependent Status, Divorce/Separation, or Death of Subscriber.
☐ **Transfer** Complete entire section		New Plan CSP: New Billing Group: Reason: Retiree Drug Subsidy: ☐ Yes ☐ No Actively Working: ☐ Yes ☐ No Enrolled in Medicare Part: ☐ A ☐ B ☐ D
☐ **Addition** Complete WHO, REASON and SECTION C below		**Who :** ☐ Spouse ☐ Civil Union ☐ Domestic Partner ☐ Dependent(s) **Reason:** ☐ Open Enrollment ☐ Loss of Coverage ☐ Birth/Adoption ☐ Other: ☐ Date of Marriage ☐ Date of Civil Union ☐ Date of Partnership

C. Additional Information	Spouse	Dependent	Dependent
Social Security Number:			
Last Name:			
First Name, Middle Initial:			
Date of Birth: (MM/DD/YYYY)			
Gender and Disability Status:	☐ M ☐ F / ☐ Disabled	☐ M ☐ F / ☐ Disabled	☐ M ☐ F / ☐ Disabled
Primary Care Physician (PCP) ID Number: PCP Name: (If an existing patient, check "Yes".)	☐ Yes	☐ Yes	☐ Yes
Check all that apply:	☐ Actively employed ☐ Not actively employed	☐ Full-time Student (Age 19 - 23)	☐ Full-time Student (Age 19 - 23)
Prior Carrier What coverage you had prior to this. Policy Number: Carrier: From Date: Thru Date:			

D. Coordination of Benefits		Spouse	Dependent	Dependent
Medicare	Check appropriate box and list effective date:	☐ Part A ☐ Part B ☐ Part D	☐ Part A ☐ Part B ☐ Part D	☐ Part A ☐ Part B ☐ Part D
Pharmacy ☐ Same for all Effective Date:	Policy Number: Carrier: Policy Holder: Group Number:	BIN: PCN:	BIN: PCN:	BIN: PCN:
Medical ☐ Same for all	Policy Number: Carrier: Policy Holder: Effective Date:			

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

Employee Signature X _____ Date _____