Healthy New York Member Enrollment Form

Mailing Address: Healthy New York Department, 14 Central Park Drive, Hookset, NH 03106 • 1-800-216-0778

UnitedHealthcare®
Oxford

THANK YOU FOR CHOOSING AN OXFORD PRODUCT FOR YOU AND YOUR FAMILY.

IMPORTANT:

PLEASE PRINT AND PRESS DOWN FIRMLY WHEN COMPLETING THIS FORM.

IN ORDER TO PROCESS THE ATTACHED FORM AND BEGIN COVERAGE, ALL FIELDS MUST BE COMPLETED ACCURATELY AND IN ITS ENTIRETY.

BE SURE TO:

- Use only blue or black ballpoint pen
- Enter all dates using the MM/DD/YYYY format
- Employer and employee signatures are required
- List any coordinating coverage (coverage in addition to this coverage)
- List any coverage you had prior to this coverage
- Attach disability paperwork, if applicable
- Check "full-time student" in the child column if the child is between the ages of 19-26 and a full-time student at an accredited institution
- Check "young adult" in the child column if the child is under the age of 30, eligible, and enrolling onto the young adult option. The young adult will also need to list their qualifying event, address and signature. Please note: The young adult option creates a new right that allows a young adult or their parent to purchase health insurance through the parent's group health insurance policy if the young adult does not otherwise qualify as a dependent due to age. There is a separate premium for the young adult option, which the young adult or the young adult's parents must pay.
- Submit this form within 31 days of the requested effective date or within 60 days of the qualifying event for COBRA or State Continuation

IF YOU HAVE ANY QUESTIONS, PLEASE FEEL FREE TO CALL CUSTOMER SERVICE AT

1-800-216-0778

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A. Group Information (To be completed by the **employer**)

Please print neatly using black or blue ballpoint pen • ALL DATES MUST BE: MM/DD/YYYY

Group Number	Group Name	Plan CSP	Billing Group	Date of Hire	Effective Date	Occupation
				/ /	/ /	

☐ On Leave of Absence ☐ Union Employee	☐ Retired ☐ Disabled	COBRA/Young Adult/SC Qualifying Event Event Date / /	**Employer Signature** X Date / /

B. Applicant Details (To be completed by the **employee**)

	Employee/Subscriber	Spouse	Child	Child
Social Security Number:				
Last Name:				
First Name, Middle Initial:				
Date of Birth: (MM/DD/YYYY)	/ /	/ /	/ /	/ /
Gender and Disability Status: (Check appropriate boxes.)	☐ M ☐ F / ☐ Disabled	☐ M ☐ F / ☐ Disabled	☐ M ☐ F / ☐ Disabled	☐ M ☐ F / ☐ Disabled
Primary Care Physician (PCP) ID Number: PCP Name: (If an existing patient of PCP, check "Yes".)	☐ Yes	☐ Yes	☐ Yes	☐ Yes
Check all that apply:		☐ Domestic Partner	☐ Full-time Student ☐ Young Adult	☐ Full-time Student ☐ Young Adult
Prior Carrier (List coverage prior to this.) ☐ Same for all — Carrier:				
Policy Number:				
From Date	/ /	/ /	/ /	/ /
Thru date::	/ /	/ /	/ /	/ /

C. Coordination of Benefits

		Employee/Subscriber	Spouse	Child	Child
Medicare Coverage	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 / /	☐ Part A / / ☐ Part B / / ☐ Part D / /
Pharmacy ☐ Same for all	Policy Number:				
	Carrier:				
	Policy Holder:				
Effective Date: / /	Group Number:	BIN: PCN:	BIN: PCN:	BIN: PCN:	BIN: PCN:
Medical ☐ Same for all	Policy Number:				
	Carrier:				
	Policy Holder:				
	Effective Date:	/ /	/ /	/ /	/ /

I understand that my enrollment and benefits are in accordance with those described in the applicable Oxford Health Plans (NY), Inc. HMO Certificate. I understand that, in order to qualify for HMO benefits, I and any enrolled dependents must choose an Oxford affiliated physician for primary care and secure a referral from that physician to an Oxford-affiliated specialist physician for all specialist care. I authorize any health provider or insurer to furnish Oxford Health Plans (NY), Inc. any records concerning me or any enrolled member of my family for whom information is requested. A photographic copy of this authorization shall be valid as the original. I understand that any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation

Employee's/Young Adult's Address (Apt #)			**Employee's/Young Adult's Signature**	Date
City	State	Zip	X	/ /