New York Individual Plan Enrollment Application and Physician Selection Form

Application Instructions:

Please supply all the information requested on this form.

We want to process your application quickly, but, if this form is incomplete, we will have to return it.

- Be sure to include:
  - Dates of birth
  - Social Security numbers
  - Choice of Oxford physicians
  - Information on other coverage you have or have had (including Medicare)
- Attach proof of Applicant's (or responsible adult) address.
  Name and address on proof must be exactly the same as name and address in Section 1 inside.
  Acceptable proofs of address include photocopies of:
  - Valid New York State driver's license
  - Voter Registration Card
  - Current income tax return, current lease or current utility bill
  - If mailing address is different than street address, please provide mailing address under separate cover
- Select the type of coverage you want.
  Check the box for the level of coverage you want.
  Child only coverage is only available to applicants 20 years of age or younger.
  Note: If enrolling on child only coverage please list the youngest child as the applicant.
  The Dependent Coverage Extension through age 29 is available for all coverage options excluding child only.
- Applicant must sign the HMO Agreement in Section 3.
- Return the signed application.
  Keep a copy for your own records.
- Include the first month's premium, payable to Oxford Health Plans.

Note: The effective date you are eligible for is based on the date of the receipt of your application.

If you have any questions, call us at **1-800-969-7480.**

UnitedHealthcare®
Oxford

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1 Applicant Information

LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____

STREET ADDRESS*_____ APT. NO _____

CITY _____ STATE_____ ZIP _____

HOME PHONE _____ WORK PHONE _____

1. Are you eligible for health coverage under you or your spouse's employer plan? ❑ yes ❑ no
2. Are you or any dependents either eligible for, or currently on, Medicare for any reason? ❑ yes ❑ no
   a. If "Yes", please enter Name: _____
3. What kind of coverage do you want? ❑ NY Individual Platinum (HMO) ❑ NY Individual Gold (HMO) ❑ NY Individual Silver (HMO) ❑ NY Individual Bronze (HMO) ❑ NY Individual Platinum (POS)***
4. If 20 years or younger, do you want to opt for the child only plan? ❑ Yes ❑ No
   a. If yes, what coverage tier do you want? ❑ Single ❑ 2 children ❑ 3+ Children
5. What coverage tier do you want (leave blank if opting for child only plan)? ❑ Single ❑ Couple ❑ Parent/Children ❑ Family
6. Additional Benefit Options:
   a. Dependent Coverage Extension through age 29 ❑ Yes ❑ No
7. When do you want your coverage to begin? _____/_____/_____ MONTH DAY YEAR

*If mailing address is different than street address, please provide mailing address under separate cover.

***THE NY INDIVIDUAL PLATINUM POS IS ONLY AVAILABLE TO APPLICANTS THAT WERE EXISTING OXFORD POS INDIVIDUAL MEMBERS AS OF THE PRODUCT WITHDRAWAL TERMINATED EFFECTIVE 12/31/2013.

2 Enrollment Information

LAST NAME FIRST NAME M.I.	SEX	BIRTH DATE	AGE	SOCIAL SECURITY NO.	PRIMARY CARE PHYSICIAN	OBSTETRICIAN/GYNECOLOGIST**
APPLICANT					NAME ID#	NAME ID#
SPOUSE					NAME ID#	NAME ID#
CHILD					NAME ID#	NAME ID#
CHILD					NAME ID#	NAME ID#
CHILD					NAME ID#	NAME ID#

**Women choose OB/GYN in addition to PCP.

Applicant must sign below

3 HMO Agreement

I understand that my enrollment and benefits are in accordance with those described in the applicable Oxford Health Plans (NY), Inc. HMO contract. 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 any records concerning me or any enrolled member of my family for whom information is requested. A photographic copy of this authorization shall be as valid as the original. I certify that, as of the date my Oxford coverage becomes effective, neither I nor my spouse have Medicare or any other group medical coverage except for that named in this application. I certify that all the above information is correct.

Any person who knowingly and with 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 be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

X_____

APPLICANT SIGNATURE DATE

Insurer Use Only _____

DATE INITIALS ID#

Broker Information (if applicable)

Broker/Agency Name:_____

Broker/Agency Code: _____

Writing Agent Code: _____

For Application Questions Call 1-800-969-7480

Pediatric Dental Essential Health Benefit

All Oxford Individual plans will include the required pediatric essential health benefits.

Please retain a copy for your records. Mail or express application to:

Individual Product Department
14 Central Park Drive
Hooksett, NH 03106

Don't forget!

- **Sign your application!**
- **Enclose proof of Applicant's address!**
- **Be sure to enclose first month's premium!**