New York Member Enrollment Form – OHI

MAILING ADDRESS: P. O. Box 7085, Bridgeport CT 06601 • 1-800-444-6222 • *www.oxfordhealth.com*

UnitedHealthcare® OXFORD®

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
	Verartex, Inc.			/ / 1978	/ /	Textiles

☐ On Leave of Absence ☐ Retired
☐ Union Employee ☐ Disabled

COBRA/SC Qualifying Event — Event Date / /

Employer Signature X Claude Simon — Date 12 15 / 2013

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

	Employee/Subscriber	Spouse	Child	Child
Social Security Number:	106 50 1158			
Last Name:	Simon			
First Name, Middle Initial:	Claude			
Date of Birth: (MM/DD/YYYY)	03 / 05 / 1956	/ /	/ /	/ /
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	☐ Full-time Student
Prior Carrier (List coverage prior to this.) ☐ Same for all — Carrier:	Empire BC/BS			
Policy Number:	2434001			
From Date	12 / 1 / 2012	/ /	/ /	/ /
Thru date::	11 / 30 / 2013	/ /	/ /	/ /

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:	Empire BC/BS			
Policy Holder:	Claude Simon			
Effective Date: / / Group Number:	2434001 BIN: PCN:	BIN: PCN:	BIN: PCN:	BIN: PCN:
Medical ☐ Same for all — Policy Number:				
Carrier:	Empire BC/BS			
Policy Holder:	Claude Simon			
Effective Date:	/ /	/ /	/ /	/ /

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. I further understand that if I do not adhere to these requirements, I will be eligible only for out-of-network health insurance coverage under the terms of the Certificate. 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 also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. 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.

Employee's Address (Apt #)
71 Tonjes Road

City: Callicoon — State: NY — Zip: 12723

Employee's Signature — Date

X Claude Simon 12 / 15 / 2013