



New Jersey Individual Application/Change Request Form – OHP

Oxford Health Plans (NJ), Inc.

Mailing Address: Attn: Individual Product Department, 14 Central Park Drive, Hooksett, NH 03106 1-800-767-3840 www.oxfordhealth.com

INSTRUCTIONS AND ELIGIBILITY REQUIREMENTS

Instructions

- Except for section G, you must complete sections A through I, and sign and date this form, as well as any additional pages you may need to submit with it to provide further requested information.
- Please PRINT except when a signature is requested.
- If a dependent child is disabled and you want to continue his or her coverage beyond the limiting age describe this in “Other Change” in Section A, and attach proof of disability.
- If a dependent is a full-time post-secondary student, you must check the box in Section D.
- You can obtain the providers’ correct names and addresses from the appropriate provider directory.
- “Previous Coverage” and “Other Health Coverage” includes coverage under a: group health plan resulting from employment, whether with a private or public (governmental) employer, including such coverage continued through a COBRA election or state continuation provisions; a church plan, Medicare, Medicaid, NJFamilyCare, or another individual health benefits plan.
- IF YOU HAVE ANY QUESTIONS concerning the benefits and services provided by or excluded under this policy, contact a member services representative at 1-800-216-0778 before signing this form.
- KEEP A COPY OF THIS COMPLETED APPLICATION! Coverage must be verified with Oxford Health Plans, Inc. prior to visiting with a specialist or admission to a hospital.

Eligibility

- A. Eligibility requirements are set forth under the Individual Health Coverage Reform Act of 1992, P.L. 1992, c. 161 (N.J.S.A. 17B:27A-2 et seq.).
- B. You MUST be a New Jersey resident.
- C. EXCEPT as F. below applies, you and family members you wish to cover MUST NOT be eligible to be covered under a: group health plan; a group health benefits plan; a governmental plan (not including Medicaid); a church plan; or Medicare.
- D. You and any family members you wish to cover are NOT eligible for a standard individual health benefits plan if covered by another individual health benefits plan UNLESS you are replacing the other individual health benefits plan by the one for which you are submitting this application.
- E. If you do not specify an effective date in the application, your effective date shall be no later than the first day of the month following the month in which the completed application was dated and we receive premium payment directly or through our duly authorized agent, UNLESS you submit your application during the October Open Enrollment Period (see F. below).
- F. You may apply for coverage for yourself and family members who are covered under a group health plan, group health benefits plan, a governmental plan, a church plan or Medicare during the October Open Enrollment Period IF you wish to replace the current coverage with a more comprehensive individual health benefits plan. The effective date of coverage under the individual health benefits plan in this instance will be January 1 of the calendar year following the October Open Enrollment Period. You SHOULD NOT terminate current coverage until the new coverage is effective.

CONDITIONS OF ENROLLMENT - APPLICANT ACKNOWLEDGEMENTS AND AGREEMENTS

On behalf of myself and the dependents listed in this Enrollment/Change Request form, I acknowledge that:

1. I authorize any physician or medical professional, hospital, clinic or other medical care institution, carrier, consumer reporting agency, and any employer to give Oxford Health Plans, Inc., or any consumer reporting agency acting on behalf of Oxford Health Plans, Inc., information pertaining to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition relevant to me or a minor dependent applying for coverage. I agree that this authorization shall be valid for 30 months from the date I sign this Enrollment/Change Request form, unless revoked at an earlier date.
2. I agree that, if I revoke this authorization before it expires, such revocation shall not affect any action that Oxford Health Plans has taken in reliance on the authorization.
3. I understand I may receive a copy of this authorization if I request one.
4. I agree Oxford Health Plans, Inc. will provide coverage in accordance with the terms of the contract for the individual plan.
5. I understand that my enrollment and the enrollment of my listed dependents in an Oxford Health Plans individual plan is effective upon acceptance by Oxford Health Plans, Inc.
6. I agree that the provision of coverage and benefits is contingent upon payment of premiums and may be terminated in accordance with the terms of the individual plan if premiums are not paid timely.

MISREPRESENTATIONS

Any person who includes any false or misleading information on a Nongroup Enrollment/Change Request Form for a health benefits plan is subject to criminal and civil penalties.



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A. Type of Activity – To be completed by Applicant. Refer to instructions on cover before completing this form. Print clearly.

Activity – Check all that apply		Effective Date/ Date of Event	Reason
ADD	<input type="checkbox"/> Enrollment of a new Subscriber	____/____/____	_____
	<input type="checkbox"/> Add Spouse	____/____/____	_____
	<input type="checkbox"/> Add Civil Union Partner	____/____/____	_____
	<input type="checkbox"/> Add Domestic Partner	____/____/____	_____
	<input type="checkbox"/> Add Dependent Child	____/____/____	_____
REMOVE	<input type="checkbox"/> Remove Subscriber	____/____/____	_____
	<input type="checkbox"/> Remove Spouse	____/____/____	_____
	<input type="checkbox"/> Remove Civil Union Partner	____/____/____	_____
	<input type="checkbox"/> Remove Domestic Partner	____/____/____	_____
	<input type="checkbox"/> Remove Dependent Child	____/____/____	_____
OTHER CHANGE	<input type="checkbox"/> Name Change	____/____/____	_____
	<input type="checkbox"/> Change Plan	____/____/____	_____
	<input type="checkbox"/> Other	____/____/____	_____
	<input type="checkbox"/> Add/Change Primary/OB/Gyn	____/____/____	_____

B. Applicant Information Name (Last, First, MI): _____

SSN: _____ Birthdate (mm/dd/yyyy) _____ Male Female

Are you a resident of New Jersey? Yes No Do you maintain a home in any other state? Yes No *If yes:*
 Name of State: _____ Number of months you live there each year: _____

Address Information	Primary Residence: Street/Apt: _____ City: _____ State: _____ Zip Code: _____ Phone: (____) _____	Other Residence: Street/Apt: _____ City: _____ State: _____ Zip Code: _____ Phone: (____) _____
	Your billing address: <input type="checkbox"/> Primary residence <input type="checkbox"/> Other residence <input type="checkbox"/> P.O. Box or Other (<i>specify</i>): _____	

Activity	<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Other Change <input type="checkbox"/> Continue		
	Primary Name: _____	Provider #: _____	Current Patient: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Ob/Gyn Name: _____	Provider #: _____	Current Patient: <input type="checkbox"/> Yes <input type="checkbox"/> No

Are you covered under Other Health Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes:</i> Payer Name: _____ Policy #: _____ Medicare ID#, if any: _____ Why are you applying for individual coverage? _____	Are you eligible but not covered under Other Health Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, what is it?</i> <input type="checkbox"/> Group plan via employment (<i>specify payer</i>): _____ <input type="checkbox"/> Medicaid/NJFamilyCare <input type="checkbox"/> Medicare <input type="checkbox"/> Other (<i>specify</i>): _____
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Previous Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If Yes:</i> Effective date: ____/____/____ Termination date: ____/____/____ Payer Name: _____ Policy #: _____	What was it? <input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicaid/NJFamilyCare <input type="checkbox"/> Other (<i>specify</i>): _____	What Plan Type? <input type="checkbox"/> Indemnity <input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> HMO <input type="checkbox"/> Other	Cost-sharing requirements: Deductible amount: \$ _____ Coinsurance amount: _____% Copayment amount: \$ _____
Did coverage terminate as a result of fraud or failure to pay premiums? <input type="checkbox"/> Yes <input type="checkbox"/> No Were you allowed to make a COBRA continuation election, or a continuation election under State law, if any, when coverage ended? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, did you elect to continue and remain covered for the entire continuation period available to you? <input type="checkbox"/> Yes <input type="checkbox"/> No Were you covered for 18 months or more under any previous plan(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you experienced more than a 63-day break in coverage between any previous plan, including your most recent plan and the date of this application? <input type="checkbox"/> Yes <input type="checkbox"/> No			

C. Plan Option – Check one

HMO:
 \$30 copayment

D. Other Individuals Covered – Identify individuals other than yourself for whom you are adding/changing/removing coverage. Attach additional pages if necessary, dated and signed by you. Attach proof of disability.

1. <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Civil Union Partner	2. Child <input type="checkbox"/> Full-Time Student	3. Child <input type="checkbox"/> Full-Time Student	4. Child <input type="checkbox"/> Full-Time Student
<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Other	<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Other	<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Other	<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Other
Name (last, first, MI) L: _____ F: _____ MI: _____	Name (last, first, MI) L: _____ F: _____ MI: _____	Name (last, first, MI) L: _____ F: _____ MI: _____	Name (last, first, MI) L: _____ F: _____ MI: _____
Birthdate (mm/dd/yyyy): <input type="checkbox"/> Male <input type="checkbox"/> Female / <input type="checkbox"/> Disabled	Birthdate (mm/dd/yyyy): <input type="checkbox"/> Male <input type="checkbox"/> Female / <input type="checkbox"/> Disabled	Birthdate (mm/dd/yyyy): <input type="checkbox"/> Male <input type="checkbox"/> Female / <input type="checkbox"/> Disabled	Birthdate (mm/dd/yyyy): <input type="checkbox"/> Male <input type="checkbox"/> Female / <input type="checkbox"/> Disabled
Social Security Number:	Social Security Number:	Social Security Number:	Social Security Number:

Continue on next page

Continue from previous page

1. Spouse, Domestic Partner, Civil Union Partner	2. Child	3. Child	4. Child
<p>Previous Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes:</i> Effective: ___/___/___ Termination: ___/___/___ Payer: _____ Policy #: _____</p>	<p>Previous Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes:</i> Effective: ___/___/___ Termination: ___/___/___ Payer: _____ Policy #: _____</p>	<p>Previous Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes:</i> Effective: ___/___/___ Termination: ___/___/___ Payer: _____ Policy #: _____</p>	<p>Previous Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes:</i> Effective: ___/___/___ Termination: ___/___/___ Payer: _____ Policy #: _____</p>
<p>What was it? <input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicaid/NJFamilyCare <input type="checkbox"/> Other, <i>specify:</i> _____</p>	<p>What was it? <input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicaid/NJFamilyCare <input type="checkbox"/> Other, <i>specify:</i> _____</p>	<p>What was it? <input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicaid/NJFamilyCare <input type="checkbox"/> Other, <i>specify:</i> _____</p>	<p>What was it? <input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicaid/NJFamilyCare <input type="checkbox"/> Other, <i>specify:</i> _____</p>
<p>What Plan type? <input type="checkbox"/> Indemnity <input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> HMO <input type="checkbox"/> None of the above</p>	<p>What Plan type? <input type="checkbox"/> Indemnity <input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> HMO <input type="checkbox"/> None of the above</p>	<p>What Plan type? <input type="checkbox"/> Indemnity <input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> HMO <input type="checkbox"/> None of the above</p>	<p>What Plan type? <input type="checkbox"/> Indemnity <input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> HMO <input type="checkbox"/> None of the above</p>
<p>Cost-sharing requirements: Deductible: \$ _____ Coinsurance: _____ % Copayment: \$ _____</p>	<p>Cost-sharing requirements: Deductible: \$ _____ Coinsurance: _____ % Copayment: \$ _____</p>	<p>Cost-sharing requirements: Deductible: \$ _____ Coinsurance: _____ % Copayment: \$ _____</p>	<p>Cost-sharing requirements: Deductible: \$ _____ Coinsurance: _____ % Copayment: \$ _____</p>
<p>Why did coverage end? _____</p>	<p>Why did coverage end? _____</p>	<p>Why did coverage end? _____</p>	<p>Why did coverage end? _____</p>
<p>Was continuation upon termination an option? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, was continuation elected and coverage retained for full continuation period?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Was continuation upon termination an option? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, was continuation elected and coverage retained for full continuation period?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Was continuation upon termination an option? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, was continuation elected and coverage retained for full continuation period?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Was continuation upon termination an option? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, was continuation elected and coverage retained for full continuation period?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Does total previous coverage equal 18 months or more? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Does total previous coverage equal 18 months or more? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Does total previous coverage equal 18 months or more? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Does total previous coverage equal 18 months or more? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Any breaks in coverage of more than 63 days? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Any breaks in coverage of more than 63 days? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Any breaks in coverage of more than 63 days? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Any breaks in coverage of more than 63 days? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

Continue on next page

Continue from previous page

1. Spouse, Domestic Partner, Civil Union Partner	2. Child	3. Child	4. Child
<p>Covered under Other Health Coverage Now? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes:</i> Payer Name: _____ Policy #: _____ Medicare ID #: _____</p> <p>Eligible but not covered under Other Health Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If Yes, identify the type:</i> <input type="checkbox"/> Group Payer: _____ <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid/NJFamilyCare <input type="checkbox"/> Other, <i>specify:</i> _____</p>	<p>Covered under Other Health Coverage Now? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes:</i> Payer Name: _____ Policy #: _____ Medicare ID #: _____</p> <p>Eligible but not covered under Other Health Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If Yes, identify the type:</i> <input type="checkbox"/> Group Payer: _____ <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid/NJFamilyCare <input type="checkbox"/> Other, <i>specify:</i> _____</p>	<p>Covered under Other Health Coverage Now? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes:</i> Payer Name: _____ Policy #: _____ Medicare ID #: _____</p> <p>Eligible but not covered under Other Health Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If Yes, identify the type:</i> <input type="checkbox"/> Group Payer: _____ <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid/NJFamilyCare <input type="checkbox"/> Other, <i>specify:</i> _____</p>	<p>Covered under Other Health Coverage Now? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes:</i> Payer Name: _____ Policy #: _____ Medicare ID #: _____</p> <p>Eligible but not covered under Other Health Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If Yes, identify the type:</i> <input type="checkbox"/> Group Payer: _____ <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid/NJFamilyCare <input type="checkbox"/> Other, <i>specify:</i> _____</p>
<p>Primary Care Provider: Provider ID #: _____</p>	<p>Primary Care Provider: Provider ID #: _____</p>	<p>Primary Care Provider: Provider ID #: _____</p>	<p>Primary Care Provider: Provider ID #: _____</p>
<p>Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Ob/Gyn Office Provider ID #: _____</p>	<p>Ob/Gyn Office Provider ID #: _____</p>	<p>Ob/Gyn Office Provider ID #: _____</p>	<p>Ob/Gyn Office Provider ID #: _____</p>
<p>Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If YES, complete Section E1</i></p>	<p>If last name is different from Applicant's, please explain: _____ _____</p>	<p>If last name is different from Applicant's, please explain: _____ _____</p>	<p>If last name is different from Applicant's, please explain: _____ _____</p>
<p>Home or billing addresses same as Employee? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If NO, complete Section E2</i></p>	<p>Living with Applicant? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If NO, complete Section F</i></p>	<p>Living with Applicant? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If NO, complete Section F</i></p>	<p>Living with Applicant? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If NO, complete Section F</i></p>

E. Additional Spouse/Domestic Partner/Civil Union Partner Information – <i>If not applicable, please mark as “NA.”</i>	1. Employer Name: _____ Employer Address: _____ City, State, Zip Code: _____ Employer Phone: () _____		
2a. Street/Apt: _____ Street/Apt: _____ City, State, Zip Code: _____	2b. Please explain why the address is different: _____ _____		
F. Additional Child Information – <i>Provide information below about children listed in Section D, if they have a different address. If multiple children are at an address, you may list them together. Attach additional pages as necessary, dated and signed by you.</i>			
Name(s): _____ Street/Apt: _____ Street/Apt: _____ City, State, Zip Code: _____ Reason: _____	Name(s): _____ Street/Apt: _____ Street/Apt: _____ City, State, Zip Code: _____ Reason: _____		
G. Race/Ethnicity – Response is appreciated but NOT required!	Choose a category that most closely describes you: <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Black, not of Hispanic origin <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> White, not of Hispanic origin <input type="checkbox"/> Hispanic		
H. Payment Information – indicate how you would like to make payment	<input type="checkbox"/> Check <input type="checkbox"/> Money Order		
I. Applicant's Signature	I represent that all the information supplied in this application is true and complete. I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form. Signature: _____ Date: _____		
J. Broker/General Agent Signature	Signature of Preparer: _____	Date / /	NJ Producer License #
	General Agent: Donald C. Savoy, Inc t/a Savoy Associates		Agent ID # BC0731

Writing Agent: Donald C. Savoy, Jr. BC9502