UnitedHealthcare Oxford

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 age 26 describe this in "Other Change" in Section A, and attach proof of disability.
- If you are applying to add a spouse, civil union partner, domestic partner, or child please check the applicable box in the "Add" section in A **and** identify the applicable triggering event in the reason section "Other Change" section in A.
- You can obtain the providers' correct names and addresses from the appropriate provider directory.
- 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.
- Triggering Events:
  1. Loss of eligibility for minimum essential coverage but not if lost due to non-payment of premium
  2. Dependent attained age 26 or 31 and lost coverage
  3. Marketplace changed your subsidy determination
  4. New dependent due to marriage, birth, adoption or placement for adoption, placement in foster care
  5. Gained access to New Jersey plans as a result of permanent move to New Jersey
  6. In 2014 only, non-renewal of current individual coverage; enrollment made be requested within the 30 days prior to the non-renewal of the current coverage. Check the "Other Change" section in A.

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 which means your primary residence is in New Jersey
C. You must NOT be eligible for Medicare
D. If application is made for the Catastrophic Plan the following additional requirements apply:
   1. You must be under 30 years old; OR
   2. You must have a Certificate of Exemption from the Marketplace. Attach a copy to your application.
E. The Annual Open Enrollment Period runs from October 15 through December 7 each year. Your application must be received during this time period. During the Annual Open Enrollment Period you may apply for or change coverage for yourself and family members who are currently uninsured or who are covered under another individual plan, or who are covered under a group health plan, group health benefits plan, a governmental plan, a church plan. The effective date of coverage will be January 1 of the calendar year following the Annual Open Enrollment Period.
F. The Initial Enrollment Period runs from October 1, 2013 through March 31, 2014. Your application must be received during this time period. During the Initial Enrollment Period you may apply for coverage for yourself and family members who are currently uninsured or who are covered under another individual plan, or who are covered under a group health plan, group health benefits plan, a governmental plan, a church plan. The effective date of coverage will be January 1, 2014 if the application is received by December 31, 2013 and for applications received after December 31st will be the first or fifteenth of the month following receipt of the application.
G. A Special Enrollment Period that lasts for 60 days follows the Triggering Events listed above. The effective date of a new policy will be no later than the first or fifteenth of the month following receipt of the application.
H. NOTE: If you currently have coverage the plan for which you are applying must REPLACE the current coverage but you SHOULD NOT terminate it until the new coverage is effective.

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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	☐ Enrollment of a new Subscriber	_____/_____/_____	_____
	☐ Add Spouse	_____/_____/_____	_____
	☐ Add Civil Union Partner	_____/_____/_____	_____
	☐ Add Domestic Partner	_____/_____/_____	_____
	☐ Add Dependent Child	_____/_____/_____	_____
REMOVE	☐ Remove Subscriber	_____/_____/_____	_____
	☐ Remove Spouse	_____/_____/_____	_____
	☐ Remove Civil Union Partner	_____/_____/____	_____
	☐ Remove Domestic Partner	_____/_____/_____	_____
	☐ Remove Dependent Child	_____/_____/_____	_____
OTHER CHANGE	☐ Name Change	_____/_____/_____	_____
	☐ Change Plan	_____/_____/_____	_____
	☐ Special Enrollment Period (following a Triggering Event*)	_____/_____/_____	_____
	☐ Other	_____/_____/_____	_____
	☐ Add/Change Office ID Numbers: Primary/OB/Gyn/Dentist	_____/_____/_____	_____
	**See list of Triggering Events in Instructions*		

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 or country? ☐ Yes ☐ No
If yes:
Name of State/Country:_____
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: ☐ Primary residence ☐ Other residence ☐ P.O. Box or Other *(specify)*:

Activity	☐ Add ☐ Remove ☐ Other Change ☐ Continue *If a name change, indicate prior name:*	
	Primary Name:_____ Provider #:	Current Patient: ☐ Yes ☐ No
	Ob/Gyn Name:_____ Provider #:	Current Patient: ☐ Yes ☐ No

Are you eligible for Medicare? ☐ Yes ☐ No	Are you covered under any health coverage? ☐ Yes ☐ No If yes, why are you applying for individual coverage? _____

C. Plan Option – *Check one*

HMO:
☐ Gold HMO ☐ Platinum HMO

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. ☐Spouse ☐Domestic Partner ☐Civil Union Partner	**2. Child**	**3. Child**	**4. Child**
☐ Add ☐ Remove ☐ Other	☐ Add ☐ Remove ☐ Other	☐ Add ☐ Remove ☐Other	☐ Add ☐ Remove ☐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):	Birthdate (mm/dd/yyyy):	Birthdate (mm/dd/yyyy):	Birthdate (mm/dd/yyyy):
☐ Male ☐ Female / ☐ Disabled	☐ Male ☐ Female / ☐ Disabled	☐ Male ☐ Female / ☐ Disabled	☐ Male ☐ Female / ☐ Disabled
Social Security Number:	Social Security Number:	Social Security Number:	Social Security Number:
Eligible for Medicare? ☐ Yes ☐ No Covered under any health coverage? ☐ Yes ☐ No	Eligible for Medicare? ☐ Yes ☐ No Covered under any health coverage? ☐ Yes ☐ No	Eligible for Medicare? ☐ Yes ☐ No Covered under any health coverage? ☐ Yes ☐ No	Eligible for Medicare? ☐ Yes ☐ No Covered under any health coverage? ☐ Yes ☐ No

Continue on next page.

Continue from previous page.

1. Spouse Domestic Partner Civil Union Partner	2. Child	3. Child	4. Child
Primary Care Provider: Provider ID#:_____ Current Patient? ☐Yes ☐ No	Primary Care Provider: Provider ID#:_____ Current Patient? ☐Yes ☐ No	Primary Care Provider: Provider ID#:_____ Current Patient? ☐Yes ☐ No	Primary Care Provider: Provider ID#:_____ Current Patient? ☐Yes ☐ No
Ob/Gyn Office Provider ID#:_____ Current Patient? ☐Yes ☐ No	Ob/Gyn Office Provider ID#:_____ Current Patient? ☐Yes ☐ No	Ob/Gyn Office Provider ID#:_____ Current Patient? ☐Yes ☐ No	Ob/Gyn Office Provider ID#:_____ Current Patient? ☐Yes ☐ No
If last name is different from Applicant's, please explain: _____	If last name is different from Applicant's, please explain: _____	If last name is different from Applicant's, please explain: _____	If last name is different from Applicant's, please explain: _____
Home address same as Applicant? ☐ Yes ☐ No *If NO, complete Section E*	Home address same as Applicant? ☐ Yes ☐ No *If NO, complete Section F*	Home address same as Applicant? ☐ Yes ☐ No *If NO, complete Section F*	Home address same as Applicant? ☐ Yes ☐ No *If NO, complete Section F*

E. Additional Spouse/Domestic Partner/Civil Union Partner Information – ***If not applicable, please mark as "NA."***

a. Street/Apt:_____

Street/Apt:_____

City, State, Zip Code: _____

b. Please explain why the address is different:
_____

_____

F. Additional Child Information – ***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, signed and dated.***

Name(s):_____
Street/Apt:_____
City, State, Zip Code: _____
Reason:_____

Name(s):_____
Street/Apt:_____
City, State, Zip Code: _____
Reason:_____

G. Race/Ethnicity – R*esponse is appreciated but NOT required!*

Choose a category that most closely describes you:

☐American Indian or Alaskan Native ☐Black, not of Hispanic origin
☐Asian or Pacific Islander ☐White, not of Hispanic origin
☐Hispanic

H. Payment Information – ***indicate how you would like to make payment***	☐ Check ☐ 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 Savoy Associates		Agent ID # BC0731

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, Inc. 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 Oxford Health Plans individual plan is subject to 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.