

# New Jersey Individual Application/Change Request Form - OHI

Oxford Health Insurance, Inc.

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

## Instructions

### Subscriber Complete Sections - A-H

**Section A - Type of Activity:**

- Provide all information that applies to the reason you are completing this application/change form.

**Section B - Subscriber Information:**

- Complete all information in order for your application to be processed.

**Section C - Plan Option:**

- Check box(es) indicating options for coverage and type of contract.

**Section D - Individuals Covered:**

- Add/Change/Remove - Use "A", "C", or "R" to indicate whether you are adding, changing or removing coverage for an individual.
- Print your full name along with the name(s) of your dependent(s), if applicable. Indicate Sex, Birthdate, and Social Security Number for each individual listed.
- If a dependent is a full-time college student, you must attach a current course schedule or a letter from the school confirming full-time student status (12 or more credits). If dependent is disabled and being continued beyond the limiting age, attach proof of disability.

**Section E - Pre-Existing Conditions Statement:**

- Complete this section for all new enrollments.

**Section F - Previous Insurance:**

- Complete this section for all new enrollments or coverage changes. Coverage includes individual or group coverage, governmental coverage, a church plan, or Medicare or Medicaid (including NJ FamilyCare).

**Section G - Dependent Information:**

- Complete this section for all new enrollments or coverage changes.

**Section H - Availability of Coverage****Section I - Race/Ethnicity - Responding to this question is optional and NOT required.****Section J - Payment Information****Section K - Subscriber Signature:**

- Complete this section for all new enrollments, coverage changes and terminations.
- Subscriber must sign and date the Application/Change Request Form in order for it to be processed.

### Conditions of Enrollment

**Subscriber Acknowledgments and Agreements**

On behalf of myself and the dependents listed, I agree to or with the following:

- (a)** I authorize the sources stated below to give to Oxford Health Insurance, Inc. ("OHI") or any consumer reporting agency acting on its behalf, information about me or my minor children, if applying for coverage. Such information will pertain to employment, other health coverage, and medical advise, treatment or supplies for any physical or mental condition. Authorized sources are any physician or medical professional; any hospital, clinic or other medical care institution; any carrier; any consumer reporting agency; any employer.
- (b)** I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which OHI has taken in reliance on the authorization. I understand this authorization will not be valid after 30 months, if not revoked earlier.
- (c)** I know that I have a right to receive a copy of the authorization if I request one.
- (d)** I agree that a photocopy of this authorization is as valid as the original.

## Instructions (continued)

### Conditions of Enrollment (continued)

2. I acknowledge by enrolling in a OHI individual policy, coverage is provided by OHI in accordance with the contract.
3. Enrollment of myself and of the listed dependents into the plan is effective on acceptance by OHI.
4. Coverage and benefits are contingent on timely payment of premiums and may be terminated as provided in the policy.

### **Misrepresentation**

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

### **Eligibility Requirements**

1. Eligibility requirements are determined under the Individual Health Coverage Reform Act of 1992, P.L. 1192, c. 161.
2. You must be a New Jersey resident.
3. You and any family members you wish to cover must not be eligible to be covered under:
  - (a) a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan; or
  - (b) Medicare. (See eligibility requirements in item 5 below)
4. 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 the other plan is being replaced by the plan being applied for with this application.
5. If the requested effective date is not completed, your effective date shall be no later than the first of the month following the month in which the completed application was dated and premium payment are received by us or our duly authorized agent. However, with respect to applications submitted during the October Open Enrollment Period by persons who are eligible for coverage under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan, or persons who wish to replace their current health benefit plan with a more comprehensive individual health benefits plan, the effective date of coverage shall be January 1 of the following calendar year. Current coverage should not be terminated until new coverage is in effect.



A UnitedHealthcare Company

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## A. Type of Activity - Refer to instructions before completing this form. Print Clearly

1. Enrollment	2. Change- <i>Check all that apply</i>	Date of Event	Reason	3. Remove or Terminate- <i>Check all that apply</i>	
<input type="checkbox"/> New Subscriber Requested Effective Date ____/____/____	<input type="checkbox"/> Add spouse	____/____/____		<b>Effective Date</b>	
	<input type="checkbox"/> Add Domestic Partner	____/____/____		<input type="checkbox"/> Remove Applicant*	____/____/____
	<input type="checkbox"/> Add dependent child	____/____/____		<input type="checkbox"/> Remove Spouse*	____/____/____
	<input type="checkbox"/> Name Change	____/____/____		<input type="checkbox"/> Add Domestic Partner	____/____/____
	<input type="checkbox"/> Plan Change	____/____/____		<input type="checkbox"/> Remove Dependent Child*	____/____/____
	<input type="checkbox"/> Other	____/____/____		*Please complete Add/Change/Remove and Name columns in Section D.	
	<input type="checkbox"/> Add/Change PCP or OB/GYN				

## B. Subscriber Information - Complete Sections B-H

Social Security Number	Last Name, First Name, M.I.		Home Telephone ( ) ( ) ( )	Work Telephone ( ) ( ) ( )
Home Address	Apt No.	City, State		Zip Code
Primary Address	Apt No.	City, State		Zip Code
Are you a resident of the State of New Jersey? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Do you maintain a residence in any other state? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of state _____ How much time do you spend there each year? _____				

## C. Plan Option

**1. Select a Plan:**

**A. Indemnity Single deductible options (select one)**  
 Plan A/50  \$1,000  \$2,500  \$5,000  \$10,000  
 Plan B  \$1,000  \$2,500  
 Plan C  \$1,000  \$2,500  
 Plan D  \$1,000

**B. PPO Plans**

	Physician	All other
	Deductible	Copay
<input type="checkbox"/> Plan C	\$1,000	\$15/visit
<input type="checkbox"/> Plan C	\$2,500	\$30/visit
	Ded. and 70%/30%	
	Ded. and 70%/30%	

**C. EPO Plans** (In-network coverage only; Deductible, coinsurance & copayments apply)  
 Basic and Essential EPO  
 Basic and Essential Enhanced

**2. Type of Contract:**  Single  Adult & Child(ren)  Family  Husband/Wife

## D. Individuals Covered - List individuals for whom you are adding/changing/removing coverage. Attach sheet to list additional children (attach proof if full-time student).

	(A)dd (C)hange (R)emove	Last Name, First Name, M.I.	Sex		Birthdate	Social Security Number	Primary PCP ID	OB/GYN ID	Previous Coverage Check if yes
			M	F	MM/DD/YYYY				
Subscriber					____/____/____				<input type="checkbox"/> Yes
Spouse					____/____/____				<input type="checkbox"/> Yes
Domestic Partner					____/____/____				<input type="checkbox"/> Yes
Child					____/____/____				<input type="checkbox"/> Yes
Child					____/____/____				<input type="checkbox"/> Yes
Child					____/____/____				<input type="checkbox"/> Yes

WHITE COPY: OXFORD

PINK COPY: OFFICE

YELLOW COPY: MEMBER

## E. Pre-Existing Conditions Statement

Note: This information may ONLY be used to determine if a condition is a pre-existing condition. You CANNOT be denied coverage under a health benefits plan on the basis of accurate response to the following questions. Carriers can only use the information to expedite the processing of claims.

1. During the past 6 months, have you or any dependent covered had or been diagnosed as having any of the following?  Yes  No If "Yes" check appropriate box(es) below:

- |                                                                   |                                                                                        |
|-------------------------------------------------------------------|----------------------------------------------------------------------------------------|
| <input type="checkbox"/> a. Alcoholism or Drug Abuse              | <input type="checkbox"/> h. Heart Disorder or Condition or Chest Pain                  |
| <input type="checkbox"/> b. Arthritis                             | <input type="checkbox"/> i. High Blood Pressure                                        |
| <input type="checkbox"/> c. Blood Disorder                        | <input type="checkbox"/> j. Kidney or Liver Disorder                                   |
| <input type="checkbox"/> d. Back or Neck Disorder, Injury or Pain | <input type="checkbox"/> k. Lung or Respiratory Disorder                               |
| <input type="checkbox"/> e. Cancer or Tumors                      | <input type="checkbox"/> l. Mental or Nervous Disorder                                 |
| <input type="checkbox"/> f. Diabetes                              | <input type="checkbox"/> m. Paralysis, Stroke or Epilepsy                              |
| <input type="checkbox"/> g. Gastro or Intestinal Disorder         | <input type="checkbox"/> n. Does pregnancy exist?<br>Expectant due date ____/____/____ |

2. During the past 6 months, have you or any dependent to be covered:

a. been examined or treated by a physician or other healthcare provider for any condition, illness, or injury other than as stated in Question 1.  
 Yes  No

b. been advised to have treatment or surgery or testing that has not been done?  Yes  No

c. been admitted to a hospital or other healthcare facility as an inpatient?  
 Yes  No

d. taken prescribed medications?  Yes  No

Please give details for "Yes" answers to any part of Questions 1 or 2 on a separate sheet of paper. This separate sheet should be signed and dated.

## E Previous Insurance

If "Yes" to " previous coverage, please provide the following:

Name \_\_\_\_\_  Individual  Group  Other (Specify) \_\_\_\_\_ Plan Type:  Indemnity  PPO  POS  HMO  
Deductible \_\_\_\_\_ Coinsurance \_\_\_\_\_ Copayment \_\_\_\_\_  
Effective Date \_\_\_\_\_ Termination Date \_\_\_\_\_ Carrier Name \_\_\_\_\_ Policy Number \_\_\_\_\_

## G. Dependent Information

Does any dependent listed in Section D live at a different address than the Subscriber?  Yes  No

If "Yes", identify the individual(s) and at what address? \_\_\_\_\_

Explain the circumstances \_\_\_\_\_

If any dependent's last name differs from yours, explain the circumstances \_\_\_\_\_

## H Availability of Coverage

Are you or any person named on this application eligible for coverage under a Group Health Plan, Governmental Plan, Church Plan, Medicare, Medicaid, or any successor program?  Yes  No

If "Yes", identify the individual(s), give name of carrier, policy number and identify coverage type. \_\_\_\_\_

Are you or any person named on this application covered under a group or governmental plan, a church plan, or Medicare?  Yes  No

If "Yes", identify the individual(s), give name of carrier, policy number and identify coverage type. \_\_\_\_\_

Was previous coverage, if any, terminated because person covered under the plan committed fraud or failed to pay premiums?  Yes  No

If "Yes", identify the individual(s), and briefly describe the circumstances. \_\_\_\_\_

Were any of the individuals to be covered under an individual plan given the opportunity to continue previous coverage, if any, under COBRA or a similar state continuation law?  Yes  No

If "Yes", did the individual(s) remain covered for the entire period that continuation was available to him or her?  Yes  No

Identify any person who did not continue for entire period available \_\_\_\_\_

Were any of the individuals to be covered under an individual plan, as of the date of this application, continuously covered under a previous plan or plans for a period of 18 or more months without a break in coverage of 63 or more days?

Yes  No If "Yes", identify the individual(s). \_\_\_\_\_

Were any of the individuals' most recent prior credible coverage under a group health plan, governmental plan, church plan or health insurance coverage offered in connection with any such plan?  Yes  No If yes identify the individual (s) \_\_\_\_\_

**Please include a Certificate of Creditable Coverage, if available.**

## I Race/Ethnicity (Responding to this question is optional and not required)

Choose a category that most closely describes you:

- a. American Indian or Alaskan Native  
 b. Asian or Pacific Islander  
 c. Black, not of Hispanic origin  
 d. Hispanic  
 e. White, not of Hispanic origin

## J. Payment Information

Monthly Payment Instrument:  Check       Money Order

## K. Applicant Signature

If you have questions concerning the benefits and services provided by or excluded under this policy, contact a Customer Service Representative at 1-800-767-3840 before signing this form.

I represent that all the information supplied in this application is true and complete. I hereby agree to the conditions of enrollment on the front side of the subscriber copy of this application/change request.

**X**

Subscriber Signature (Required)

Date

E-Mail Address

## L. Broker/General Agent Information

Signature of Preparer	Date	NJ Producer License #
General Agent Name		Agent ID

Subscriber copy may be used as a temporary ID card for 30 days from the effective date if authorized by OHI. Coverage must be verified with OHI prior to visiting a specialist or admission to a hospital.

