New Jersey Individual Enrollment Checklist

Oxford Health Plans

Thank you for using Health Plan One to obtain your individual health insurance. Follow the steps below to finalize your enrollment.

1. **New Jersey Individual Application/Change Request Form**
   To be completed by all enrolling individuals.
   Make sure you sign and date the form in Section K.
   Important Note: When completing application, please use younger adult as the Subscriber.

2. **Initial Premium Check-**
   First month's premium check payable to
   Oxford Health Plans; check or money orders only- no cash or credit cards.

3. **Proof of Residency- you must include one of the following:**
   - a copy of a utility bill, showing the applicants name and NJ address
   - copy of applicants NJ drivers license

Send all enrollment materials and check or money order **Payable to OXFORD** to Health Plan One at the address listed below:

Health Plan One, LLC
1000 Bridgeport Ave., 4th FL
Shelton, CT 06484
877-567-5267

08/13/07

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 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 November 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 or a church plan during the November 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 November 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.

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

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	_____/_____/_____	_____
	☐ Other	_____/_____/_____	_____
	☐ 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: ☐ Primary residence ☐ Other residence ☐ P.O. Box or Other *(specify)*:

Activity

☐ Add ☐ Remove ☐ Other Change ☐ Continue

Primary Name:_____ Provider #: Current Patient: ☐ Yes ☐ No

Ob/Gyn Name:_____ Provider #: Current Patient: ☐ Yes ☐ No

Are you covered under Other Health Coverage? ☐ Yes ☐ No

If yes:

Payer Name: _____

Policy #: _____

Medicare ID#, if any:

Why are you applying for individual coverage? _____

Are you **eligible but not covered** under Other Health Coverage? ☐Yes ☐No

If yes, what is it?

☐ Group plan via employment (*specify payer*): _____

☐ Medicaid/NJFamilyCare

☐ Medicare

☐ Other (*specify*): _____

Previous Coverage? ☐ Yes ☐ No

If Yes:

Effective date: _____/_____/_____ Termination date: _____/_____/_____

Payer Name:_____

Policy #:_____

What was it?
☐ Individual
☐ Group
☐ Medicaid/NJFamilyCare
☐ Other *(specify):*

What Plan Type?
☐ Indemnity
☐ PPO
☐ POS
☐ HMO
☐ Other

Cost-sharing requirements:
Deductible amount: $_____
Coinsurance amount: _____%
Copayment amount: $_____

Did coverage terminate as a result of fraud or failure to pay premiums? ☐ Yes ☐ No

Were you allowed to make a COBRA continuation election, or a continuation election under State law, if any, when coverage ended? ☐ Yes ☐ No

If Yes, did you elect to continue and remain covered for the entire continuation period available to you? ☐ Yes ☐ No

Were you covered for 18 months or more under any previous plan(s)? ☐ Yes ☐ 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? ☐ Yes ☐ 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. ☐Spouse ☐Domestic Partner ☐Civil Union Partner	2. Child ☐Full-Time Student	3. Child ☐Full-Time Student	4. Child ☐Full-Time Student
☐ 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:

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

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1. Spouse, Domestic Partner, Civil Union Partner	**2. Child**	**3. Child**	**4. Child**
Covered under Other Health Coverage Now? ☐ Yes ☐ No *If yes:* Payer Name: ______________________________ Policy #: ________________ Medicare ID #:____________ **Eligible but not** covered under Other Health Coverage? ☐ Yes ☐ No *If Yes*, identify the type: ☐Group Payer:______________________ ☐Medicare ☐Medicaid/NJFamilyCare ☐Other, *specify:*________________ ____________________________	Covered under Other Health Coverage Now? ☐ Yes ☐ No *If yes:* Payer Name: ______________________________ Policy #: ________________ Medicare ID #:____________ **Eligible but not** covered under Other Health Coverage? ☐ Yes ☐ No *If Yes*, identify the type: ☐Group Payer:______________________ ☐Medicare ☐Medicaid/NJFamilyCare ☐ Other, *specify:*________________ ____________________________	Covered under Other Health Coverage Now? ☐ Yes ☐ No *If yes:* Payer Name: ______________________________ Policy #: ________________ Medicare ID #:____________ **Eligible but not** covered under Other Health Coverage? ☐ Yes ☐ No *If Yes*, identify the type: ☐Group Payer:______________________ ☐Medicare ☐Medicaid/NJFamilyCare ☐ Other, *specify:*________________ ____________________________	Covered under Other Health Coverage Now? ☐ Yes ☐ No *If yes:* Payer Name: ______________________________ Policy #: ________________ Medicare ID #:____________ **Eligible but not** covered under Other Health Coverage? ☐ Yes ☐ No *If Yes*, identify the type: ☐Group Payer:______________________ ☐Medicare ☐Medicaid/NJFamilyCare ☐ Other, *specify:*________________ ____________________________
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
Employed? ☐ Yes ☐ No *If YES, complete Section E1*	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 or billing addresses same as Employee? ☐ Yes ☐ No *If NO, complete Section E2*	Living with Applicant? ☐ Yes ☐ No *If NO, complete Section F*	Living with Applicant? ☐ Yes ☐ No *If NO, complete Section F*	Living with Applicant? ☐ Yes ☐ No *If NO, complete Section F*

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

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 – 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 # **1063131** General Agent: **HEALTH PLAN ONE** Agent ID # **BN9240**