UnitedHealthcare Oxford

Addition/Termination Change Form

P.O. Box 31391, Salt Lake City, UT 84131 • 1-800-444-6222
Oxford insurance products are underwritten by Oxford Health Insurance, Inc.

Please print neatly using black or blue ballpoint pen

All dates must be: MM/DD/YYYY

A. Employer/Employee Information (To be completed by the employer)

Group ID Number:	Group Name:
Employee Insurance ID Number:	Employer Signature X Date / /
Employee Name:	

B. Transaction

Transaction	Effective Date	Required Information
☐ **Termination**	/ /	**Who:** ☐ Employee ☐ Spouse/Partner ☐ Dependent(s) ☐ NY Young Adult **Reason:** ☐ Left Employer ☐ Discontinue COBRA ☐ Switched Plans ☐ Discontinue NY Young Adult ☐ Other:
☐ **Change** Address changes can be done online or by calling Oxford Client Services. For Gender, check M for Male, F for Female or N for Non-binary.	/ /	**Who:** Last Name: First Name: Effective Date: / / Date of Birth: / / Other: SS#: Middle Initial: Gender: ☐ M ☐ F ☐ N
☐ **COBRA or State Continuation**	/ /	**Who:** ☐ Employee ☐ Spouse/Partner* ☐ Dependent(s)* **Reason:** ☐ Left Employer ☐ Hours Reduction ☐ Other: Date of Event: / / *A **New Member Enrollment Form** is required for: Loss of Dependent Status, Divorce/Separation, or Death of Subscriber.
☐ **Transfer** Complete entire section	/ /	New Plan CSP/Plan ID: New Billing Group: Reason: Retiree Drug Subsidy: ☐ Yes ☐ No Actively Working: ☐ Yes ☐ No Enrolled in Medicare Part: ☐ A ☐ B ☐ D
☐ **Addition** Complete WHO, REASON and SECTION C below	/ /	**Who:** ☐ Spouse ☐ Civil Union ☐ Domestic Partner ☐ Dependent(s) **Reason:** ☐ Open Enrollment ☐ Loss of Coverage ☐ Birth/Adoption ☐ Other: ☐ Date of Marriage ☐ Date of Civil Union ☐ Date of Partnership

C. Additional Information

	Spouse	Dependent	Dependent
Social Security Number:			
Last Name:			
First Name, Middle Initial:			
Date of Birth: (MM/DD/YYYY)	/ /	/ /	/ /
Gender and Disability Status: In the Gender field, please check M for Male, F for Female or N for Non-binary.	☐ M ☐ F ☐ N / ☐ Disabled	☐ M ☐ F ☐ N / ☐ Disabled	☐ M ☐ F ☐ N / ☐ Disabled
Primary Care Physician (PCP) ID Number: PCP Name: (If an existing patient, check "Yes".)	☐ Yes	☐ Yes	☐ Yes
Check all that apply:	☐ Actively employed ☐ Not actively employed	☐ Full-time Student (Age 19 - 23)	☐ Full-time Student (Age 19 - 23)
Prior Carrier What coverage you had prior to this.	Policy Number: Carrier: From Date: / / Through Date: / /	Policy Number: Carrier: From Date: / / Through Date: / /	Policy Number: Carrier: From Date: / / Through Date: / /

D. Coordination of Benefits

	Spouse	Dependent	Dependent
Medicare 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 / /
Pharmacy ☐ Same for all Effective Date: / / Policy Number: Carrier: Policy Holder: Group Number:	BIN: PCN:	BIN: PCN:	BIN: PCN:
Medical ☐ Same for all Policy Number: Carrier: Policy Holder: Effective Date:	/ /	/ /	/ /

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.

Employee Signature X _____ Date _____ / /