

Addition/Termination Change Form

HealthPass, 7120 Lake Ellenor Drive, Orlando, FL 32809 Fax: 888.354.7277
 Many transactions can be completed online at the employer area of our website www.oxfordhealth.com
 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	Date		
Employee Name:		X	/ /		
B. Transaction		Effective Date		Required Information	
<input type="checkbox"/> Termination	/ /	Who: <input type="checkbox"/> Employee <input type="checkbox"/> Spouse/Partner <input type="checkbox"/> Dependent(s) <input type="checkbox"/> NY Young Adult	Reason: <input type="checkbox"/> Left Employer <input type="checkbox"/> Discontinue COBRA <input type="checkbox"/> Switched Plans	<input type="checkbox"/> Discontinue NY Young Adult <input type="checkbox"/> Other:	
<input type="checkbox"/> Change Address changes can be done online or by calling Oxford.	/ /	Who: Last Name: First Name:	Effective Date: / / Date of Birth: / / Other:	SS#: Middle Initial: Gender: <input type="checkbox"/> M <input type="checkbox"/> F	
<input type="checkbox"/> COBRA or State Continuation	/ /	Who: <input type="checkbox"/> Employee <input type="checkbox"/> Spouse/Partner* <input type="checkbox"/> Dependent(s)*	Reason: <input type="checkbox"/> Left Employer <input type="checkbox"/> Hours Reduction <input type="checkbox"/> Other:	Date of Event: / /	
*A New Member Enrollment Form is required for: Loss of Dependent Status, Divorce/Separation, or Death of Subscriber.					
<input type="checkbox"/> Transfer Complete entire section	/ /	New Plan CSP: New Billing Group: Reason:	Retiree Drug Subsidy: Actively Working: Enrolled in Medicare Part: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> D	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Addition Complete WHO, REASON and SECTION C below	/ /	Who: <input type="checkbox"/> Spouse <input type="checkbox"/> Civil Union <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Dependent(s)	Reason: <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Loss of Coverage <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Other:	<input type="checkbox"/> Date of Marriage <input type="checkbox"/> Date of Civil Union <input type="checkbox"/> Date of Partnership	
C. Additional Information		Spouse		Dependent	
Social Security Number:					
Last Name:					
First Name, Middle Initial:					
Date of Birth: (MM/DD/YYYY)		/ /		/ /	
Gender and Disability Status:		<input type="checkbox"/> M <input type="checkbox"/> F / <input type="checkbox"/> Disabled		<input type="checkbox"/> M <input type="checkbox"/> F / <input type="checkbox"/> Disabled	
Primary Care Physician (PCP) ID Number: PCP Name: (If an existing patient, check "Yes".)		<input type="checkbox"/> Yes		<input type="checkbox"/> Yes	
C check all that apply:		<input type="checkbox"/> Actively employed <input type="checkbox"/> Not actively employed		<input type="checkbox"/> Full-time Student (Age 19 - 23)	
Prior Carrier What coverage you had prior to this.	Policy Number: Carrier: From Date: / / Thru Date: / /				
D. Coordination of Benefits		Spouse		Dependent	
Medicare	C check appropriate box and list effective date:	<input type="checkbox"/> Part A / / <input type="checkbox"/> Part B / / <input type="checkbox"/> Part D / /		<input type="checkbox"/> Part A / / <input type="checkbox"/> Part B / / <input type="checkbox"/> Part D / /	
Pharmacy <input type="checkbox"/> Same for all	Policy Number: Carrier: Policy Holder: Group Number:				
Effective Date: / /	BIN: PCN:				
Medical <input type="checkbox"/> Same for all	Policy Number: Carrier: Policy Holder: Effective Date: / /				

ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR INSURANCE IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES

Employee Signature

X

Date

/ /