UnitedHealthcare
Oxford

New Jersey Nongroup Enrollment/Change Request Form – OHI

Oxford Health Insurance, Inc.
Mailing Address: PO Box 31370, Salt Lake City, UT 84131-0370 1-800-657-8205 *www.uhone.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 of the "Other Change" section in A.
- Eligible for Medicare means the person satisfies the requirements for Medicare but has not yet enrolled for Medicare. Covered under Medicare Parts A or B means you have Medicare and CANNOT enroll for an individual plan.
- You can obtain the providers' correct names and addresses from the appropriate provider directory. You may also obtain each provider's NPI number by contacting the provider directly. Providers with multiple office locations and individual providers who belong to more than one practice or provider entity may have more than one NPI number. You should confirm the correct NPI number for the specific provider and office location where you will be seen by contacting that office directly.
- For provider addresses, include the zip code plus the four digit extension (9 digits.)
- IF YOU HAVE ANY QUESTIONS concerning the benefits and services provided by or excluded under this policy, contact a member services representative at 1-800-657-8205 before signing this form.
- KEEP A COPY OF THIS COMPLETED APPLICATION! Coverage must be verified with Oxford Health Insurance, 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 which means your primary residence is in New Jersey.
C. You must not be enrolled for Medicare Parts A or B.
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 notice that you qualify for an exemption with an exemption certificate number (ECN) from the Marketplace. Attach a copy of that notice to your application.

The Annual Open Enrollment Period begins November 1 and ends January 31 each year, and is the designated period of time during which 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, or a church plan. Your application must be signed, dated and mailed during the Annual Open Enrollment Period. The effective date of coverage applied for by December 31 will be January 1 of the immediately following year. The effective date of coverage applied for between January 1 and January 31 will be February 1 of the same year.

A **Special Enrollment Period** that lasts for 60 days follows the listed Triggering Events. The effective date of a new policy will be no later than the first of the month following receipt of the application. In addition, if the Triggering Event is the loss of eligibility for minimum essential coverage, the Special Enrollment Period includes the 60 days prior to the Triggering Event. 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.

Triggering Events Please note: You must provide evidence of the Triggering Event with your enrollment form.

1. Loss of eligibility for minimum essential coverage or medically needy coverage but not if lost due to non-payment of premium
2. Voluntary or involuntary non-renewal of a non-calendar year plan
3. Loss of pregnancy-related coverage or access to health care services through coverage for your unborn child
4. Dependent attained age 26 or 31 and lost coverage
5. Marketplace determination that you are no longer eligible for a subsidy
6. Marriage (at least one spouse must have had coverage for at least 1 day within the prior 60 days)
7. Confirmation of pregnancy by a health care provider
8. Birth, adoption or placement for adoption, placement in foster care or gaining a child through a child support order or other court order, but only you and the new dependent are eligible for the special enrollment
9. Gained access to New Jersey plans as a result of permanent move to New Jersey (must have had coverage for at least 1 day within the prior 60 days)
10. Application to NJ FamilyCare submitted during open enrollment period or during a special enrollment period is found ineligible
11. Domestic abuse or spousal abandonment necessitating coverage apart from the perpetrator
12. Erroneous enrollment or non-enrollment due to error, misrepresentation, misconduct or inaction of entity providing enrollment assistance or a carrier's violation of a material provision of the plan in relation to a covered person
13. Your effective date under a health reimbursement arrangement known as either an ICHRA or QSEHRA

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A. Type of Activity - to be completed by Applicant. *Refer to instructions on front before completing this form. Print clearly.*

	Activity - Check all that apply	Date of Event	Reason
ADD	☐ Enrollment of a new Applicant	____/____/____	_____
	☐ Add Spouse	____/____/____	_____
	☐ Add Civil Union Partner	____/____/____	_____
	☐ Add Domestic Partner	____/____/____	_____
	☐ Add Dependent Child	____/____/____	_____
REMOVE	☐ Remove Insured	____/____/____	_____
	☐ Remove Spouse	____/____/____	_____
	☐ Remove Civil Union Partner	____/____/____	_____
	☐ Remove Domestic Partner	____/____/____	_____
	☐ Remove Dependent Child	____/____/____	_____
OTHER CHANGE	☐ Name Change	____/____/____	_____
	☐ Change Plan	____/____/____	_____
	☐ Special Enrollment Period (due to a Triggering Event*)	____/____/____	
	☐ Other	____/____/____	_____
	**See list of Triggering Events in Instructions; provide evidence of the triggering event with the enrollment form.*		

B. Applicant Information

Name (Last, First, MI): _____ _____ _____

SSN: _____

Birthdate (mm/dd/yyyy) ____/____/_____

☐ Male ☐ Female

Email:
By providing an email address you consent to receive information, including the policy, by electronic means. _____

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: _____
Home Phone: (____) _____
Cell Phone: (____) _____

Other Residence:
Street/Apt.: _____
City: _____ State: _____
ZIP Code: _____
Home Phone: (____) _____
Cell Phone: (____) _____

Your billing address: ☐ Primary residence ☐ Other residence ☐ PO Box or Other *(specify)*

COVERAGE INFORMATION

Are you, as the applicant, requesting to be covered under the policy for which you are completing this enrollment form? ☐ Yes ☐ No

If yes, complete the Activity section below and respond to the Medicare and health coverage questions below before proceeding to the Plan Options in Part C.

If you are not requesting to be covered under the policy for which you are completing this enrollment form but you are requesting coverage for multiple children only, do not complete the Activity section below and do not respond to the Medicare and health coverage questions below. Proceed to the Plan Options in Part C. Use Part D, Other Individuals Covered, to name the children for whom you are applying for coverage.

ACTIVITY

☐ Add ☐ Remove ☐ Continuation ☐ Other Change *If a name change, indicate prior name:*

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

Address: _____ Zip+4 _____

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

Address: _____ Zip+4 _____

Are you eligible for Medicare? ☐ Yes ☐ No

Are you covered under Medicare Parts A or B? ☐ Yes ☐ No

Please note: If you are eligible for Medicare, the individual policy will coordinate as secondary payor to what Medicare paid or would have paid. Individual policies do not operate as Medicare supplement policies.

Are you covered under any health coverage? ☐ Yes ☐ No

If yes, why are you applying for individual coverage?

_____

_____

C. Plan Option - *Check one*

☐ Silver Copay Select 80 ☐ Silver Copay Select 70 ☐ Bronze Copay Select 50

D. Individuals to be 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	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Social Security Number:	Social Security Number:	Social Security Number:	Social Security Number:
Eligible for Medicare? ☐ Yes ☐ No Covered under Medicare Parts A or B? ☐ Yes ☐ No Covered under any health coverage? ☐ Yes ☐ No	Eligible for Medicare? ☐ Yes ☐ No Covered under Medicare Parts A or B? ☐ Yes ☐ No Covered under any health coverage? ☐ Yes ☐ No	Eligible for Medicare? ☐ Yes ☐ No Covered under Medicare Parts A or B? ☐ Yes ☐ No Covered under any health coverage? ☐ Yes ☐ No	Eligible for Medicare? Yes ☐ No ☐ Covered under Medicare Parts A or B? ☐ Yes ☐ No Covered under any health coverage? ☐ Yes ☐ No
Primary Care Provider: NPI#:_____ Address:_____ _____zip+4_____ Current Patient? ☐ Yes ☐ No	Primary Care Provider: NPI#:_____ Address:_____ _____zip+4_____ Current Patient? ☐ Yes ☐ No	Primary Care Provider: NPI#:_____ Address:_____ _____zip+4_____ Current Patient? ☐ Yes ☐ No	Primary Care Provider: NPI#:_____ Address: _____ _____zip+4_____ Current Patient? ☐ Yes ☐ No
Ob/Gyn Office: NPI#:_____ Address:_____ _____zip+4_____ Current Patient? ☐ Yes ☐ No	Ob/Gyn Office: NPI#:_____ Address:_____ _____zip+4_____ Current Patient? ☐ Yes ☐ No	Ob/Gyn Office: NPI#:_____ Address:_____ _____zip+4_____ Current Patient? ☐ Yes ☐ No	Ob/Gyn Office: NPI#:_____ Address:_____ _____zip+4_____ Current Patient? ☐ Yes ☐ No
If last name is different from Applicant's, please explain: _____ Home address same as Applicant? Yes No *If NO, complete Section E*	If last name is different from Applicant's, please explain: _____ Home address same as Applicant? Yes No *If NO, complete Section F*	If last name is different from Applicant's, please explain: _____ Home address same as Applicant? ☐ Yes ☐ No *If NO, complete Section F*	If last name is different from Applicant's, please explain: _____ 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.: _____

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 - *Response is appreciated but NOT required!*

Choose a category that most closely describes you:

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

H. Payment Information - *Indicate how you would like to be billed and make payment.*

Initial Payment with Application: ☐ Check ☐ EFT ☐ Credit Card

Ongoing Payments: ☐ Monthly EFT ☐ Monthly Direct Bill ☐ Quarterly Direct Bill

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 # ☐ NPN
General Agent:		Agent ID #

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 Insurance, Inc., or any consumer reporting agency acting on behalf of Oxford Health Insurance, 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 Insurance, 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 Insurance, 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 Insurance, Inc. individual plan is subject to acceptance by Oxford Health Insurance, 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.

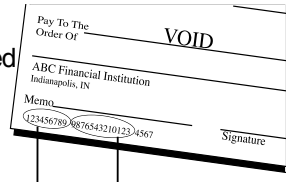
MISREPRESENTATIONS

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.

ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION — ONLY IF PAYING BY EFT

I (we) hereby authorize Oxford Health Insurance, Inc. to initiate debit entries to the account indicated below. I also authorize the named financial institution to debit the same to such account.

I agree this authorization will remain in effect until you actually receive written notification of its termination from me.



Type of Account:
☐ Checking ☐ Savings

Nine-digit Routing No.

Acct No.

324F-O-1116

Financial Institution's Name _____

Address _____

City, State, ZIP _____

Draft On _____ _____

Day Date Signed

X _____

Authorized Account Signature

CREDIT CARD AUTHORIZATION — ONLY IF PAYING BY CREDIT CARD

I authorize Oxford Health Insurance, Inc. to bill my American Express/MasterCard/Visa account for the Total Premium for Mode Chosen.

Type of Card: ☐ MasterCard ☐ Visa ☐ American Express

Exp. Date: Month Year

ZIP Code:

Card Number:

X _____

Signature of Authorized User

Charge On _____

Day

Only select a charge date between the 1st and 28th of the month.

Note: Some card issuers/financial institutions charge cash advance fees on insurance payments.

325F-O-1116

Feb 28 2023 09:44:27 am

CONSENT TO RECEIVE ELECTRONIC RECORDS AND TO CONDUCT TRANSACTIONS ELECTRONICALLY

By submitting this consent form or a health insurance application or HMO enrollment form, you hereby consent to presentation, delivery, storage retrieval and transmission of "Communications" related to "Our Transaction" as electronic records instead of in paper form.

For the purposes of this form, "Our Transaction" means the entirety of the business relationship between you and us. "Communications" includes, but is not limited to:

1. Your application or enrollment form, including subsequent amendments;
2. Information related to Our Transaction that we are required to provide or make available in writing such as privacy notices or fraud warnings;
3. Documents related to Our Transaction such as policy, certificate, or evidence of coverage forms, claim forms, explanation of benefit forms, premium notices or privacy policies and notices (e.g., HIPAA Notices or Privacy Practices) or other administrative forms (to the extent permitted by applicable law);
4. Any emails, faxes, recorded telephone calls, or other electronic transmissions of information between you and us and an insurance producer contracted with us, or between us and any third party.

Subject to our obligations to protect your privacy, we may, at our sole discretion, post Communications on a website (in which case they will be sent or received, as the case may be, regardless of whether or not we own, operate or control the website). Or send them in or attached to an email. Please be advised that communication by unencrypted email presents a risk of disclosure to, or interception by, unintended third parties. You must promptly tell us about any change to your electronic or physical mailing address, or other contact information.

You acknowledge that you can receive or access Communications because you have the following:

- A telephone
- A computer and printer
- A device or computer program for listening to audio CDs, mp3, WAV or other common computer audio files
- An Internet browser
- Access to the Internet
- A valid email address
- Adobe Acrobat Reader or other sufficient PDF reader

You can request a free copy of any Communications, or withdraw your consent to receive electronic Communications at any time by sending a written request to:

Policy Administration
PO Box 31372
Salt Lake City, UT 84131-0372

☐ I hereby consent to receive Communications and Transaction Documents electronically, as per the aforementioned conditions. All of the Communications between the time you submit your consent and withdraw your consent will remain valid and binding on both you and us notwithstanding your withdrawal.

☐ I hereby DO NOT consent to receive Communications and Transaction Documents electronically, as per the aforementioned conditions. If you do not consent, we will conduct all future business with you in paper form.

X _____
Primary Applicant *(You)*

X _____
Parent/Guardian *(if you are a minor)* Relationship

_____
Primary Applicant *(You)* Email Address

_____
Primary Applicant *(You)* Email Address

_____
Date

_____
Policy ID Number

UnitedHealthcare Oxford Form 1095-B Electronic Delivery Consent Notice

This notice is for electronic delivery of Form 1095-B only. It will stay in place until you tell us that you don't want to get Form 1095-B electronically.

What is Form 1095-B?

This is the IRS form that you will use when you prepare your tax return to show you had minimum essential coverage (MEC). Form 1095-B shows this information about your health coverage:

- Type of coverage you had
- Period of coverage
- Who was covered (including dependents)

Electronic delivery of Form 1095-B

You agree to receive Form 1095-B electronically instead of receiving a paper copy. If you also want a paper copy, call the number on your health plan ID card. We will keep sending future 1095-B forms electronically.

You may print Form 1095-B to use when preparing your tax return.

You may have already agreed to get other communications electronically. We need you to also agree to get Form 1095-B electronically.

To stop getting electronic delivery of Form 1095-B and to get a paper copy

You can stop getting electronic delivery of Form 1095-B at any time and choose to get a paper copy. To do this:

1. Log in to myuhone.com
2. Select Profile or under Quick Links, select Account Settings for Document Delivery
3. Under Email Electronic Document Preferences, select No for Electronic Document Delivery 1095-B and select Update

You may also send your request in writing to:

Oxford Health Insurance, Inc.
PO Box 31372
Salt Lake City, UT 84131-0372

Be sure to include the following information with your request:

- Primary insured's name
- Date of your request
- Primary insured's email address
- Policy ID Number
- And make sure you sign the request

You can also ask for a free paper copy of Form 1095-B by calling the member phone number on your health plan ID card. We will keep sending Form 1095-B electronically until you tell us not to.

Undeliverable Emails

We will send Form 1095-B to the email address you give us. If we get a message that the form is undeliverable, we will send you a paper copy of Form 1095-B.
To update your email address:

1. Log in to myuhone.com
2. Select Profile
3. Under Contact Options, enter your email address and select Update

To be sure that you can receive emails from us, add the UnitedHealthcare "From" email address to your email address book or safe list.

If your UnitedHealthcare Oxford health plan terminates

If you no longer have a UnitedHealthcare Oxford health plan, we will send Form 1095-B for the months you had coverage with us. If you need a prior year's form and don't have access to the member portal, call customer service to request the form.

Requirements to Receive and Keep Electronic Information

To receive and keep electronic information, you must have access to a computer or other device that can get to the Internet and a printer. You must have an email address. Also, you must have Adobe Acrobat Reader® version 6.0 or higher which lets you open Portable Document Format or "PDF" files.

Form 1095-B is available for three years from the year the form was issued.

_____ _____
Primary Applicant's Name Primary Applicant's Email Address

X _____ _____
Primary Applicant's Signature Date

_____
ID Number

Feb 28 2023 09:44:27 am

45321-O-1117

668I-O-0323

Consolidated Appropriations Act Compensation Disclosure Statement

Oxford Health Insurance, Inc. pays compensation to licensed agents and brokers, who are contracted and appointed with our company, when they sell Oxford Health Insurance products.

Compensation is paid to recognize the broker's services rendered for the sale of the plan. It may be paid directly to the agent/broker or to a licensed entity with which the broker is employed or affiliated. The plan's premium is the same regardless how the plan is purchased or if any compensation is paid.

Per the Consolidated Appropriations Act of 2020, this statement informs you of the compensation earned for the sale of this plan.

- If you used a licensed agent or broker, then $6 of this plan's premium per member per month is paid in compensation as long as the plan is active.

- If you did not use any sales assistance, then $0 compensation is paid.