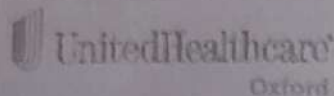


New Jersey Large Employer – Member Enrollment/Change Request Form Oxford Health Insurance, Inc. (OHI) or Oxford Health Plans (NJ), Inc. (OHP)



Group Information – To be completed by Employer:

Group Name:

Group Number:

Plan CSP/Plan ID:

UTC Credit Global 9668519

Oxford Health Insurance, Inc. or Oxford Health Plans (NJ), Inc.

Mailing Address: P.O. Box 29142, Hot Springs, AR 71903 1-800-444-6222

A. Type of Activity – To be completed by Employer. Refer to instructions on page 4 before completing this form. Print clearly.

Activity – Check all that apply	Effective Date/ Date of Event	Date of Hire/Reason for Change
1. ADD		
<input checked="" type="checkbox"/> Enrollment of a new Subscriber	6/1/2024	Date of Hire: 3/05/2024
<input checked="" type="checkbox"/> Add Spouse		
<input type="checkbox"/> Add Civil Union Partner		
<input type="checkbox"/> Add Domestic Partner		
<input checked="" type="checkbox"/> Add Dependent Child		
<input type="checkbox"/> Add Over-Age Child as a Dependent Under 31 (and complete section A 4)		
2. REMOVE		
<input type="checkbox"/> Employee Withdrawal/Termination		
<input type="checkbox"/> Remove Spouse		
<input type="checkbox"/> Remove Civil Union Partner		
<input type="checkbox"/> Remove Domestic Partner		
<input type="checkbox"/> Remove Dependent Child		
<input type="checkbox"/> Remove Over-Age Child as a Dependent Under 31		
3. OTHER CHANGE		
<input type="checkbox"/> Name Change		
<input type="checkbox"/> Change Plan		
<input type="checkbox"/> Other		
<input type="checkbox"/> Add/Change Office ID Numbers: Primary/OB/Gyn		
4. COVERAGE CONTINUATION		
<input type="checkbox"/> For Employee <input type="checkbox"/> Total Disability* <input type="checkbox"/> COBRA/NJSGC Length of Continuation (in months): <input type="checkbox"/> 18 <input type="checkbox"/> 29 Date of Loss of Coverage: / / Qualifying Event #: Date of Qualifying Event: / / *Attach proof of disability.	<input type="checkbox"/> For Spouse/Civil Union Partner/Domestic Partner Length of Continuation (in months): <input type="checkbox"/> 18 <input type="checkbox"/> 36 Date of Loss of Coverage: / / Qualifying Event: Date of Qualifying Event: / / *Civil union partners are eligible to make an election pursuant to NJSGC, if applicable	<input type="checkbox"/> For Dependent or Over-age Child <input type="checkbox"/> COBRA/NJSGC Length of Continuation (in months): <input type="checkbox"/> 18 <input type="checkbox"/> 36 Loss of Coverage: / / Qualifying Event #: Date: / / <input type="checkbox"/> Dependent Under 31 Qualifying Event #:

B. Employee Information – To be completed by the Employee

Name (Last, First, MI):	SSN:	Birthdate (mm/dd/yyyy):	<input type="checkbox"/> Male <input checked="" type="checkbox"/> Female
Egyson ROCHELLE D	219194183	07/29/1968	
Street/Apt:			
14562 Montfort Drive			
City:	State:	Zip Code:	
Asie	OH	186655	
Preferred Phone: <input type="checkbox"/> Home <input checked="" type="checkbox"/> Cell <input type="checkbox"/> Work	Alternate Phone: <input type="checkbox"/> Home <input checked="" type="checkbox"/> Cell <input type="checkbox"/> Work		
902 663-5118	239-765-7896		
Email:			
rochelle68@gmail.com			
Employer Name:	Employment Date:		
UTC CREDIT GLOBAL	03/05/24		
Address:	City:		State:
	W-B Stanton		PA
Phone:	Zip Code:	Hours worked per week:	
(765) 513-9902		45+	