



Oxford Health Plans

Health Coverage History Form

Mailing Address: P.O. Box 7081, Bridgeport, CT 06601-7081 • 800-444-6222

To Be Completed By Subscriber (Please Print)

LAST NAME										FIRST NAME & MI											
STREET ADDRESS										APT. NO.			HOME PHONE			BUSINESS PHONE			COUNTY		
CITY					STATE		ZIP			SOCIAL SECURITY NO.					<input type="checkbox"/> MALE		BIRTH DATE				
														<input type="checkbox"/> FEMALE		MO.	DAY		YEAR		

PLEASE PROVIDE THE FOLLOWING INFORMATION CONCERNING YOUR HEALTH COVERAGE DURING THE PAST 18 MONTHS PRIOR TO YOUR OXFORD EFFECTIVE DATE (CHECK ONE).

- NO PRIOR COVERAGE ONE CARRIER PRIOR TO YOUR EFFECTIVE DATE WITH OXFORD
 MULTIPLE CARRIERS PRIOR TO YOUR EFFECTIVE DATE WITH OXFORD

PRIOR CARRIER NAME:		POLICY/MEMBER NUMBER		DATE OF HIRE WITH PREVIOUS EMPLOYER		TYPE OF POLICY	
				/ /		<input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> GROUP	
TYPE OF COVERAGE?				COVERAGE BEGIN DATE		COVERAGE END DATE	
<input type="checkbox"/> HMO OR RELATED <input type="checkbox"/> TRADITIONAL/COMPREHENSIVE <input type="checkbox"/> OTHER				/ /		/ /	
PRIOR CARRIER NAME:		POLICY/MEMBER NUMBER		DATE OF HIRE WITH PREVIOUS EMPLOYER		TYPE OF POLICY	
				/ /		<input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> GROUP	
TYPE OF COVERAGE				COVERAGE BEGIN DATE		COVERAGE END DATE	
<input type="checkbox"/> HMO OR RELATED <input type="checkbox"/> TRADITIONAL/COMPREHENSIVE <input type="checkbox"/> OTHER				/ /		/ /	

WILL YOU HAVE A SPOUSE AND/OR DEPENDENTS ON YOUR OXFORD POLICY?

- YES, I WILL HAVE A SPOUSE AND/OR DEPENDENTS ON MY POLICY. NO, I WILL NOT HAVE A SPOUSE AND/OR DEPENDENTS ON MY POLICY.

IF YOU CHECKED "NO", PLEASE SKIP THE NEXT SECTION. IF YOU CHECKED "YES", PLEASE INDICATE BELOW THE HEALTH COVERAGE HISTORY OF YOUR SPOUSE AND EACH DEPENDENT ON YOUR POLICY, DURING THE 18 MONTHS PRIOR TO THEIR OXFORD EFFECTIVE DATE.

SPOUSE/DEPENDENT NAME										SOCIAL SECURITY NO.																													
CHECK ONE <input type="checkbox"/> NO PRIOR COVERAGE <input type="checkbox"/> ONE CARRIER PRIOR TO YOUR EFFECTIVE DATE WITH OXFORD <input type="checkbox"/> MULTIPLE CARRIERS PRIOR TO YOUR EFFECTIVE DATE WITH OXFORD																																							
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																				/ /																			
TYPE OF COVERAGE																				COVERAGE BEGIN DATE										COVERAGE END DATE									
<input type="checkbox"/> HMO OR RELATED <input type="checkbox"/> TRADITIONAL/COMPREHENSIVE <input type="checkbox"/> OTHER																				/ /										/ /									
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<input type="checkbox"/> HMO OR RELATED <input type="checkbox"/> TRADITIONAL/COMPREHENSIVE <input type="checkbox"/> OTHER																				/ /										/ /									
DEPENDENT NAME										SOCIAL SECURITY NO.																													
CHECK ONE <input type="checkbox"/> NO PRIOR COVERAGE <input type="checkbox"/> ONE CARRIER PRIOR TO YOUR EFFECTIVE DATE WITH OXFORD <input type="checkbox"/> MULTIPLE INSURANCE CARRIERS PRIOR TO YOUR EFFECTIVE DATE WITH OXFORD																																							
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<input type="checkbox"/> HMO OR RELATED <input type="checkbox"/> TRADITIONAL/COMPREHENSIVE <input type="checkbox"/> OTHER																				/ /										/ /									

IF YOU NEED ADDITIONAL SPACE TO LIST YOUR DEPENDENTS, ATTACH A SHEET OF PAPER WITH THE INFORMATION TO THIS FORM.

TO THE BEST OF MY KNOWLEDGE, THE INFORMATION SHOWN ABOVE IS TRUE AND COMPLETE. I UNDERSTAND THAT FAILURE TO COMPLETE THIS FORM MAY RESULT IN DELAYED OR DENIED CLAIM PAYMENT FOR SERVICES RENDERED.

X

SIGNATURE OF SUBSCRIBER

DATE