

****Rates are per paycheck****

SEMI-MONTHLY

7/1/26-6/30/27

Oxford Gold Freedom PPO							
	Tier 1		Tier 2		Tier 3		Tier 4
Employee	290.00		325.00		387.00		515.00
Employee	563.00		683.00		795.00		975.00
Employee	390.00		445.00		510.00		820.00
Family	795.00		820.00		847.00		1,372.00

Oxford Silver Liberty EPO							
	Tier 1		Tier 2		Tier 3		Tier 4
Employee	162.00		205.00		251.00		382.00
Employee	318.00		400.00		520.00		732.00
Employee	266.00		272.00		280.00		622.00
Family	435.00		480.00		457.00		995.00

Oxford Bronze Liberty EPO HSA							
	Tier 1		Tier 2		Tier 3		Tier 4
Employee	176.00		162.00		142.00		125.00
Employee	405.00		405.00		405.00		405.00
Employee	345.00		345.00		345.00		345.00
Family	726.00		726.00		726.00		726.00

New York Member Enrollment Form – OHI



Oxford

MAILING ADDRESS: P. O. Box 29142, Hot Springs, AR 71903 • 1-800-444-6222

A. Group Information (To be completed by the employer)		Please print neatly using black or blue ballpoint pen • ALL DATES MUST BE: MM/DD/YYYY				
Group Number 1299345	Group Name Kulanu Academy	Plan CSP/Plan ID	Billing Group	Date of Hire / /	Effective Date / /	Occupation
<input type="checkbox"/> On Leave of Absence	<input type="checkbox"/> Retired	COBRA/Young Adult/SC Qualifying Event		Event Date / /	Employer Signature X	Date / /
<input type="checkbox"/> Union Employee						
B. Applicant Details (To be completed by the employee)		Employee/Subscriber	Spouse	Child	Child	
Social Security Number:						
Last Name:						
First Name, Middle Initial:						
Date of Birth: (MM/DD/YYYY)		/ /	/ /	/ /	/ /	/ /
Gender: (Check appropriate boxes.)		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> F
Primary Care Physician (PCP) ID Number: PCP Name: (If an existing patient of PCP, check "Yes".)		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Check all that apply:		<input type="checkbox"/> Domestic Partner	<input type="checkbox"/> Young Adult	<input type="checkbox"/> Young Adult	<input type="checkbox"/> Young Adult	
C. Coordination of Benefits		Employee/Subscriber	Spouse	Child	Child	
Medicare Coverage	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 / /	<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:	BIN: PCN:	BIN: PCN:	BIN: PCN:	
Medical <input type="checkbox"/> Same for all	Policy Number: Carrier: Policy Holder: Effective Date:					
<p>I understand that my enrollments and benefits are in accordance with those described in the Oxford Health Insurance Certificate. I understand that, in order to receive in-network benefits, I and any enrolled dependents must seek care through our Oxford affiliated primary care physician or through an Oxford-affiliated specialist physician with an authorized referral from the primary care physician if required. I further understand that if I do not adhere to these requirements, I will be eligible only for out-of-network health insurance coverage under the terms of the Certificate. 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. I authorize any health provider or insurer to furnish Oxford any records concerning me or any enrolled member of my family for whom information is requested.</p>						
Employee's/ Young Adult's Address		(Apt #)	Preferred Phone: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work _____			
City	State	ZIP Code	Alternate Phone: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work _____			
Email Address:			Employee's/ Young Adult's Signature X		Date / /	