

Disability Questionnaire

To Be Completed by the Oxford Plan Subscriber (please print clearly)

Subscriber Name				Oxford Member ID #			
Street Address	Apt #	City		State ZIP Code		ZIP Code	
Are you or any of your covered f	amily men	nbers disabled? (check	one)	Yes	No)	
If "Yes," please complete the sec	tions belo	w.					
Disabled Member's Name				Birthdate Month	Day	Year	
Is the disabled Member covered Medicaid)? If "Yes," please tell u		lth insurance other than	n an C	xford plan	(includi	ng Medicare or	
Name of the Other Carrier Effective Date of that Co				overage Policy Number			
Please enclose a photocopy of the	e insurance	e card.					
I attest to the best of my knowled named above (if such dependent economic support and maintenan	is a child a						
Subscriber Signature Da				 ite			
To Be Completed by Physician	(please pi	rint clearly)					
Disability Diagnosis			Plea	Please indicate the status of the disability			
			Te	emporary _		Permanent	
Description of Disability							
Date Disability Commenced		Age At Which	Vhich Disability Arose				
Is the individual listed above capable of self-sustaining employment or attending school on a full-time basis (if 19-25 years of age)?				At this time YES _ NO _		In the future? YES NO	
If 'No" was checked for any resp	onse abov	e, please provide a brie	f expl	anation.		'	

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Physician Signature:	Date:
Print Physician Name:	
Physician Office Address:	

Please return this completed form to us at:

Oxford Member Enrollment P.O. Box 29142 Hot Springs, AR 71903

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