Add/Change/Delete Form

CareConnect
Healthier Insurance™

A. Individual	Group
Member Insurance ID Number	Group ID Number
	Member ID Number
Member Name	Group Name
Member Signature	Employer Signature
____/____/____ Date	Title ____/____/____ Date

B. Transaction Complete WHO, REASON and SECTION C on reverse side.	Effective Date	Required Information
☐ **Addition**	____/____/____	Who: ☐ Spouse ☐ Domestic Partner ☐ Civil Union ☐ Dependent(s)
		Reason: ☐ Open Enrollment ☐ Loss of Coverage ☐ Birth/Adoption ☐ Marriage ☐ Civil Union ☐ Partnership ☐ Other:________
☐ **Termination**	____/____/____	Who: ☐ Employee ☐ Spouse/Partner ☐ Dependent(s) ☐ NY Young Adult
		Reason: ☐ Left Employer ☐ Discontinuation of COBRA ☐ Switched Plans ☐ Discontinuation of NY Young Adult ☐ Other:________
☐ **Change**	____/____/____	Who: Last Name:________ First Name:________ Middle Initial:________ Effective Date:____/____/____ SSN:________ Date of Birth:____/____/____ Gender: ☐ Male ☐ Female
		Reason:________
☐ **COBRA or State**	____/____/____	Who: ☐ Employee ☐ Spouse/Partner* ☐ Dependent(s)*
		Reason: ☐ Left Employer ☐ Hours Reduction ☐ Other:________ Date of Event ____/____/____ *A New Member Enrollment Form is required for Loss of Dependent Status, Divorce/Separation or Death of Subscriber
☐ **Transfer**	____/____/____	New Plan:________ New Billing Group:________ Enrolled in Medicare Part: ☐ A ☐ B ☐ D
		Reason:________

(Continued on other side)

C. Additional Information		Employee	Spouse	Dependent	Dependent
Social Security Number					
Last Name					
First Name, Middle Initial					
Date of Birth (MM/DD/YY)		/ /	/ /	/ /	/ /
Gender		☐ M ☐ F	☐ M ☐ F	☐ M ☐ F	☐ M ☐ F
Primary Care Physician (PCP)		First Name Last Name	First Name Last Name	First Name Last Name	First Name Last Name
Actively Employed		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Prior Carrier	Policy Number:				
	Carrier:				
	From Date:	/ /	/ /	/ /	/ /
	Through Date:	/ /	/ /	/ /	/ /
D. Coordination of Benefits		**Employee**	**Spouse**	**Dependent**	**Dependent**
Medicare	Check appropriate box and list effective date:	☐ Part A / / ☐ Part B / / ☐ Part D / /	☐ Part A / / ☐ Part B / / ☐ Part D / /	☐ Part A / / ☐ Part B / / ☐ Part D / /	☐ Part A / / ☐ Part B / / ☐ Part D / /
Pharmacy ☐ Same for all Effective date / /	Policy Number:				
	Carrier:				
	Policy Holder:				
	Group Number:				
		EIN:	EIN:	EIN:	EIN:
		PCN:	PCN:	PCN:	PCN:
Medical ☐ Same for all	Policy Number:				
	Carrier:				
	Policy Holder:	/ /	/ /	/ /	/ /
	Effective Date:	/ /	/ /	/ /	/ /

Please return the completed form to CareConnect by:

MAIL	EMAIL	FAX
CareConnect Attention: Group Enrollment Department 2200 Northern Blvd., Suite 104, East Hills, NY 11548	enrollment@careconnect.com	844-266-4343

CareConnect
Healthier Insurance™

CareConnect Insurance Company, Inc. ("CareConnect") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. CareConnect does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

CareConnect:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact CareConnect's Senior Director, Quality Improvement.

If you believe that CareConnect has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

CareConnect
Senior Director, Quality Improvement
2200 Northern Blvd., Suite 104, East Hills, NY 11548
Phone: 855-706-7545
TTY: 855-226-7318
Fax: 844-447-2525
Email: CareConnectAppeals@careconnect.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Senior Director, Quality Improvement is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building, Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-855-226-7318 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-226-7318 (TTY: 711).

注意:如果您使用繁體中文,您可以免費獲得語言援助服務. 請致電 1-855-226-7318 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-226-7318 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-226-7318 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-226-7318 (TTY: 711) 번으로 전화해 주십시오.

ATTENZIONE: In caso la lingua parlata sia l’italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-226-7318 (TTY: 711).

אויפמערקזאם: אויב איר רעדט אידיש, זענען פאראן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1-855-226-7318 (TTY: 711).

লক্ষ্য করনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করন 1-855-226-7318 (TTY: 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-226-7318 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-226-7318 (رقم هاتف الصم والبكم: 711).

ATTENTION: Si vous parlez français, des services d’aide linguistique vous sont proposés gratuitement. Appelez le 1-855-226-7318 (TTY: 711).

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-855-226-7318 (TTY: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-226-7318 (TTY: 711).

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-855-226-7318 (TTY: 711).

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-855-226-7318 (TTY: 711).