CareConnect℠

Large Group Member Application

Plan Selection: _____

Details • *required fields*	Applicant	Spouse	Child	Child	Child
• **Last Name:**					
• **First Name:**					
• **Social Security Number:**					
• **DOB: (MM/DD/YYYY)**	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____
• **Street Address:**					
• **City, State, Zip:**					
• **Phone Number:**					
• **E-mail Address:** For office use only.					
• **Gender**	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
PCP Name:					
PCP ID Number:					
Prior Carrier:					
• **Policy Number:**					
• **Start Date:**	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____
• **End Date:**	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____

{ Continued on reverse side. }

Large Group Member Application (continued)

CareConnect℠

Coordination of Benefits		Applicant	Spouse	Child	Child	Child
Medicare Coverage (Select box and write 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 ___/___/___	☐ Part A ___/___/___ ☐ Part B ___/___/___ ☐ Part D ___/___/___
Pharmacy	Carrier: Policy Number: Start Date: End Date:	_____ _____ _____/_____/_____ _____/_____/_____	_____ _____ _____/_____/_____ _____/_____/_____	_____ _____ _____/_____/_____ _____/_____/_____	_____ _____ _____/_____/_____ _____/_____/_____	_____ _____ _____/_____/_____ _____/_____/_____
Medical	Carrier: Policy Number: Start Date: End Date:	_____ _____ _____/_____/_____ _____/_____/_____	_____ _____ _____/_____/_____ _____/_____/_____	_____ _____ _____/_____/_____ _____/_____/_____	_____ _____ _____/_____/_____ _____/_____/_____	_____ _____ _____/_____/_____ _____/_____/_____

Group Name	Billing Group	DOH (MM/DD/YYYY)	Effective Date	Occupation
		_____/_____/_____	_____/_____/_____	
Group Number	**COBRA/YA/SC Qualifying Event**	**Event Date**	**Employer Signature**	**Date**
		_____/_____/_____		_____/_____/_____

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 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 $5,000 dollars and the stated value of the claim for each violation.

_____ _____/_____/_____

Insured Signature Date

North Shore-LIJ CareConnect Insurance Company, Inc.
Attention: Group Enrollment Department
2200 Northern Boulevard, Suite 104, East Hills, NY 11548
855-706-7545 CareConnect.com