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: PCN:	EIN: PCN:	EIN: PCN:	EIN: 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@nslijcc.com	844-266-4343