# 2017 Individual Application

CareConnect℠ Healthier Insurance™

**EPO Plan Selection†—Effective Date:** ____/____/____

☐ Standard Bronze EPO ☐ Standard Bronze HSA ☐ Standard Silver EPO ☐ Standard Gold EPO ☐ Standard Platinum EPO ☐ Tradition Platinum 30 HRx

☐ Tradition Gold 30/50 LRx ☐ Tradition Silver 40/60 LRx ☐ Value Silver 100% ☐ Value Silver 75% ☐ Value Gold 100% ☐ Value Platinum 100%

☐ Bronze HSA 70% ☐ Catastrophic ☐ Other:_____

† Summary of Benefits and Coverage documents (SBCs) for all CareConnect plans are available at CareConnect.com.

☐ **Special Enrollment Period:** ____/____/____ (Enrollment may not be approved until proof of special enrollment has been recieved.)

Check triggering event below and attach proof:

☐ Loss of minimum essential coverage ☐ Marriage/divorce/birth/adoption/foster care ☐ Change in eligibility for financial assistance

☐ Dependent attained age 26 and lost coverage ☐ Access to new plan due to permanent move ☐ Enrollment error by the Marketplace or other entity providing enrollment assistance

☐ Other:_____

| Details | Applicant | Spouse/Domestic Partner | Child | Child | Child |
|---|---|---|---|---|---|
| **Last Name*** | | | | | |
| **First Name*** | | | | | |
| **Social Security Number*** | | | | | |
| **DOB: (MM/DD/YYYY)*** | ____/____/____ | ____/____/____ | ____/____/____ | ____/____/____ | ____/____/____ |
| **Street Address*** | | | | | |
| **City, State, Zip*** | | | | | |
| **Phone Number*** | | | | | |
| **E-mail Address*** | | | | | |
| **Gender*** | ☐ Male ☐ Female | ☐ Male ☐ Female | ☐ Male ☐ Female | ☐ Male ☐ Female | ☐ Male ☐ Female |
| **PCP Name** | | | | | |
| **PCP ID Number** | | | | | |
| **Prior Carrier** | | | | | |
| **Policy Number** | | | | | |
| **Start Date** | ____/____/____ | ____/____/____ | ____/____/____ | ____/____/____ | ____/____/____ |
| **End Date** | ____/____/____ | ____/____/____ | ____/____/____ | ____/____/____ | ____/____/____ |

( * required fields)

(Continued on opposite side.)

## Coordination of Benefits

| | Applicant | Spouse/Domestic Partner | Child | Child | Child |
|---|---|---|---|---|---|
| **Additional Coverage** Please indicate if you or any covered family members have: | ☐ Medicare ☐ Medicaid | ☐ Medicare ☐ Medicaid | ☐ Medicare ☐ Medicaid | ☐ Medicare ☐ Medicaid | ☐ Medicare ☐ Medicaid |

Have you obtained stand-alone dental coverage that provides a pediatric dental essential health benefit through a NYSOH-certified stand-alone dental plan offered outside the NYSOH? ☐ Yes ☐ No

If you answered "yes", please provide the name of the company issuing the stand-alone dental coverage. _____

If you answered "no", we will provide you coverage of the pediatric dental essential health benefit.

## Broker/GA Information (if applicable)

| | Broker | Co-Broker | General Agent |
|---|---|---|---|
| **Name of Payee** | | | |
| **CareConnect's Broker and/or General Agency Code** | | | |
| **New York State License #** | | | |
| **Payee's SS # or Federal Tax ID #** | | | |
| **Commission Split** | | | |
| **Sales Representative** | | | |

The undersigned hereby requests that CareConnect Insurance Company, Inc. accept the Broker or Agent named above as an authorized person for purposes of processing any enrollment transactions for my CareConnect Insurance Company, Inc. policy. This authorization shall be effective immediately and shall remain in place until it is expressly revoked by me in writing. Further, I agree that I will be bound by the actions performed by the herein-named Broker or Agent pursuant to this Consent Form. Additionally, I agree that this Consent Form does not authorize anyone to receive individually identifiable health information about me. I acknowledge that I must notify CareConnect Insurance Company, Inc. in writing to void this agreement in the event of a change in my Broker of Record.

**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.**

_____ Print name of insured or authorized representative

_____ Signature of insured or authorized representative

_____/_____/_____ Date

_____ Description of authorized representative's authority (e.g., power of attorney, guardianship order) *Documentation must be made available at CareConnect's request.*

CareConnect
Attention: Group Enrollment
2200 Northern Blvd., Suite 104, East Hills, NY 11548
P: 855-706-7545 F: 844-266-4343 CareConnect.com

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@nslijcc.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 פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1-855-226-7318 (TTY: 711).

লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন 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).