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 ____/____/____ Date	Employer Signature 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	516-405-7859