CareConnect[SM]

Add/Change/Delete Form

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 opposite side)

Add/Change/Delete Form (continued)

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:	______ ______ ______ ______/______/______	______ ______ ______ ______/______/______	______ ______ ______ ______/______/______	______ ______ ______ ______/______/______

This can be downloaded from our website at CareConnect.com

If you have any questions, please call 855-706-7545

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