

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 <small>Complete WHO, REASON and SECTION C on reverse side.</small>	Effective Date	Required Information
<input type="checkbox"/> <b>Addition</b>	____ / ____ / ____	Who: <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Civil Union <input type="checkbox"/> Dependent(s) Reason: <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Loss of Coverage <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Marriage <input type="checkbox"/> Civil Union <input type="checkbox"/> Partnership <input type="checkbox"/> Other: _____
<input type="checkbox"/> <b>Termination</b>	____ / ____ / ____	Who: <input type="checkbox"/> Employee <input type="checkbox"/> Spouse/Partner <input type="checkbox"/> Dependent(s) <input type="checkbox"/> NY Young Adult Reason: <input type="checkbox"/> Left Employer <input type="checkbox"/> Discontinuation of COBRA <input type="checkbox"/> Switched Plans <input type="checkbox"/> Discontinuation of NY Young Adult <input type="checkbox"/> Other: _____
<input type="checkbox"/> <b>Change</b>	____ / ____ / ____	Who: Last Name: _____ First Name: _____ Middle Initial: _____ Effective Date: ____ / ____ / ____ SSN: _____ Date of Birth: ____ / ____ / ____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female Reason: _____
<input type="checkbox"/> <b>COBRA or State</b>	____ / ____ / ____	Who: <input type="checkbox"/> Employee <input type="checkbox"/> Spouse/Partner* <input type="checkbox"/> Dependent(s)* Reason: <input type="checkbox"/> Left Employer <input type="checkbox"/> Hours Reduction <input type="checkbox"/> Other: _____ Date of Event ____ / ____ / ____ *A New Member Enrollment Form is required for Loss of Dependent Status, Divorce/Separation or Death of Subscriber
<input type="checkbox"/> <b>Transfer</b>	____ / ____ / ____	New Plan: _____ New Billing Group: _____ Enrolled in Medicare Part: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> D Reason: _____

(Continued on other side)

C. Additional Information		Employee	Spouse	Dependent	Dependent
<b>Social Security Number</b>					
<b>Last Name</b>					
<b>First Name, Middle Initial</b>					
<b>Date of Birth (MM/DD/YY)</b>		____/____/____	____/____/____	____/____/____	____/____/____
<b>Gender</b>		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> F
<b>Primary Care Physician (PCP)</b>		_____ First Name _____ Last Name	_____ First Name _____ Last Name	_____ First Name _____ Last Name	_____ First Name _____ Last Name
<b>Actively Employed</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Prior Carrier</b>	Policy Number:	_____	_____	_____	_____
	Carrier:	_____	_____	_____	_____
	From Date:	____/____/____	____/____/____	____/____/____	____/____/____
	Through Date:	____/____/____	____/____/____	____/____/____	____/____/____
D. Coordination of Benefits		Employee	Spouse	Dependent	Dependent
<b>Medicare</b>	Check appropriate box and list effective date:	<input type="checkbox"/> Part A ____/____/____	<input type="checkbox"/> Part A ____/____/____	<input type="checkbox"/> Part A ____/____/____	<input type="checkbox"/> Part A ____/____/____
		<input type="checkbox"/> Part B ____/____/____	<input type="checkbox"/> Part B ____/____/____	<input type="checkbox"/> Part B ____/____/____	<input type="checkbox"/> Part B ____/____/____
		<input type="checkbox"/> Part D ____/____/____	<input type="checkbox"/> Part D ____/____/____	<input type="checkbox"/> Part D ____/____/____	<input type="checkbox"/> Part D ____/____/____
<b>Pharmacy</b> <input type="checkbox"/> Same for all _____ Effective date ____/____/____	Policy Number:	_____	_____	_____	_____
	Carrier:	_____	_____	_____	_____
	Policy Holder:	_____	_____	_____	_____
	Group Number:	_____	_____	_____	_____
	EIN:	_____	_____	_____	_____
	PCN:	_____	_____	_____	_____
<b>Medical</b> <input type="checkbox"/> 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@nsljcc.com	844-266-4343

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@nsljcc.com](mailto:CareConnectAppeals@nsljcc.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 করুন: 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).