CommunityCare

ENROLLMENT FORM

Please check one of the following: ❑ **Applying for Coverage** ❑ **Waiving (Declining) Coverage – *See "Waiver" Section below***

FOR EMPLOYER USE

Please fax completed enrollment form to (918) 594-5349 (except for new group initial enrollment)

1. **Employee Name** Last / First / Middle Initial			2. Social Security Number		3. Gender ❑ M ❑ F	4. Date of Birth		Group No.
5. Mailing Address		6. Home Phone #	**7. Marital Status:** ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Legally Separated	**8. Apply for:** ❑ Self ❑ Self & Spouse ❑ Self & 1 Child ❑ Self & Children ❑ Self & Family ❑ None (Waiver)	**9. a. HMO or POS Coverage:** ❑ HMO ❑ IDEA Plus ❑ IDEA ❑ HRA ❑ POS **HMO or POS Network:** 1. HMO Select 2. HMO Standard 1a. Plus POS Select 2a. Plus POS Standard	**9. b. PPO Coverage:** ❑ PPO **PPO Network:** 3. PPO Select 4. PPO Standard PHCS *(out of state)*	**9. c. Other Coverage:** ❑ COBRA ❑ Retiree	Div. No. / Employment Date *(full-time)*
10. City	11. State	12. ZIP						Employer/Company Name
13. a. Occupation	13. b. ❑ Hourly ❑ Salaried	14. Work Phone #						
15. a. Employee Primary Care Physician's Name		15. b. Existing Patient ❑ Yes ❑ No	15. c. PCP's Hospital or Network Affiliation		15. d. E-mail Address			Requested effective date

Notice: Enrollment in HMO or POS requires the selection of a Primary Care Physician. All Employees should refer to instructions on the reverse side of this form.

Does anyone enrolling have other coverage? ❑ No ❑ Yes If yes, please answer the following:

Name of Person Covered by other Insurance	Insurance ID number	Policyholder's name	Name of other insurance company	Other insurance company phone number

Does the other coverage include pharmacy benefits? ❑ No ❑ Yes

Use this space to list all eligible dependents *that are to be covered.* (Last name required if different from employee's.)

16. a. **Spouse's Name** First MI Last	16. b. Date of Birth	16. c. Sex ❑ M ❑ F / 16. d. Social Security Number	16. e. Is your Spouse eligible for Medicare? ❑ Yes ❑ No If yes, Medicare # _____	
16. f. Spouse Primary Care Physician's Name	16. g. Existing Patient ❑ Yes ❑ No	16. h. PCP's Hospital or Network Affiliation	16. i. Address if different from Employee	
17. a. **Dependent's Name** First MI Last	17. b. Date of Birth	17. c. Sex ❑ M ❑ F / 17. d. Social Security Number	17. e. Relationship ❑ Son ❑ Daughter Other_____	
17. f. Dependent Primary Care Physician's Name	17. g. Existing Patient ❑ Yes ❑ No	17. h. PCP's Hospital or Network Affiliation	17. i. Address if different from Employee	17. j. Disabled ❑ Yes ❑ No
18. a. **Dependent's Name** First MI Last	18. b. Date of Birth	18. c. Sex ❑ M ❑ F / 18. d. Social Security Number	18. e. Relationship ❑ Son ❑ Daughter Other_____	
18. f. Dependent Primary Care Physician's Name	18. g. Existing Patient ❑ Yes ❑ No	18. h. PCP's Hospital or Network Affiliation	18. i. Address if different from Employee	18. j. Disabled ❑ Yes ❑ No
19. a. **Dependent's Name** First MI Last	19. b. Date of Birth	19. c. Sex ❑ M ❑ F / 19. d. Social Security Number	19. e. Relationship ❑ Son ❑ Daughter Other_____	
19. f. Dependent Primary Care Physician's Name	19. g. Existing Patient ❑ Yes ❑ No	19. h. PCP's Hospital or Network Affiliation	19. i. Address if different from Employee	19. j. Disabled ❑ Yes ❑ No

❑ Waiver – Refusal of Coverage *You must complete the section below only if you are waiving (declining) any of the coverage available to you through your employer.*

This is to acknowledge that I have been given opportunity to apply for group coverage available to me and my dependents pursuant to state law through the above named employer. I hereby waive insurance coverage for:
❑ Myself ❑ My Spouse ❑ Dependent Children
I decline to apply for group insurance coverage because: ❑ Spousal coverage ❑ Medicare supplement ❑ Individual health coverage ❑ Coverage under another carrier's plan provided by the employer named above ❑ **Other**_____

I affirm that I was not pressured or forced by the employer named above, the writing agent, or CommunityCare into waiving (declining) the above noted coverage. I understand that in the event that I apply for such coverage hereafter, my application shall be subject to the applicable terms and conditions of the group services agreement/policy certificate which may impose additional limitations and waiting periods. I freely and voluntarily waive my employer's coverage. If you are declining enrollment for yourself or your dependents (including your spouse) because of other health coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

➔ **Employee's Signature** *(Terms and conditions are on reverse side)*_____ **Date** _____