

CommunityCare Enrollment Form

21+ Eligible

Please check one of the following: <input type="checkbox"/> Applying for Coverage <input type="checkbox"/> Waiving (Declining) Coverage – See “Waiver” Section below				FOR EMPLOYER USE	
1. Employee Name Last First Middle Initial		2. Social Security Number		3. Sex <input type="checkbox"/> M <input type="checkbox"/> F	
4. Date of Birth		5. Mailing Address		6. Home Phone Number ()	
7. Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated		8. Apply for: <input type="checkbox"/> Self <input type="checkbox"/> Self & Spouse <input type="checkbox"/> Self & 1 Child <input type="checkbox"/> Self & Children <input type="checkbox"/> Self & Family <input type="checkbox"/> None (Waiver)		9.a. HMO Coverage: <input type="checkbox"/> HMO <input type="checkbox"/> IDEA <input type="checkbox"/> IDEA Plus <input type="checkbox"/> HRA <input type="checkbox"/> POS HMO Network: <input type="checkbox"/> CommunityCare <input type="checkbox"/> CommCare Select	
9.b. PPO Coverage: <input type="checkbox"/> PPO PPO Network: <input type="checkbox"/> PCC <input type="checkbox"/> PCC Select <input type="checkbox"/> PHCS (out of state)		9.c. Other Coverage: <input type="checkbox"/> COBRA <input type="checkbox"/> Retiree		Group No.	
10. City		11. State		12. ZIP	
13.a. Occupation		13. b. <input type="checkbox"/> Hourly <input type="checkbox"/> Salaried		14. Work Phone Number ()	
15. a. Employee Primary Care Physician's Name		15. b. Existing Patient <input type="checkbox"/> Yes <input type="checkbox"/> No		15. c. PCP's Hospital or Network Affiliation	
				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.

Do any covered dependents have other group health insurance coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please answer the following:				
Name of Person Covered by other Insurance	Insurance ID number	Policy holder's name	Other insurance phone number	Name of other insurance company

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 <input type="checkbox"/> M <input type="checkbox"/> F	
16. d. Social Security Number		16. e. Is your Spouse Eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Medicare # _____			
16. f. Spouse Primary Care Physician's Name		16. g. Existing Patient <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> M <input type="checkbox"/> F	
17. d. Social Security Number		17. e. Relationship <input type="checkbox"/> Son <input type="checkbox"/> Daughter Other _____		17. f. Full-time Student <input type="checkbox"/> Yes <input type="checkbox"/> No	
17. g. Dependent Primary Care Physician's Name		17. h. Existing Patient <input type="checkbox"/> Yes <input type="checkbox"/> No		17. i. PCP's Hospital or Network Affiliation	
17. j. Address if different from Employee					
18. a. Dependent's Name First MI Last		18. b. Date of Birth		18. c. Sex <input type="checkbox"/> M <input type="checkbox"/> F	
18. d. Social Security Number		18. e. Relationship <input type="checkbox"/> Son <input type="checkbox"/> Daughter Other _____		18. f. Full-time Student <input type="checkbox"/> Yes <input type="checkbox"/> No	
18. g. Dependent Primary Care Physician's Name		18. h. Existing Patient <input type="checkbox"/> Yes <input type="checkbox"/> No		18. i. PCP's Hospital or Network Affiliation	
18. j. Address if different from Employee					
19. a. Dependent's Name First MI Last		19. b. Date of Birth		19. c. Sex <input type="checkbox"/> M <input type="checkbox"/> F	
19. d. Social Security Number		19. e. Relationship <input type="checkbox"/> Son <input type="checkbox"/> Daughter Other _____		19. f. Full-time Student <input type="checkbox"/> Yes <input type="checkbox"/> No	
19. g. Dependent Primary Care Physician's Name		19. h. Existing Patient <input type="checkbox"/> Yes <input type="checkbox"/> No		19. i. PCP's Hospital or Network Affiliation	
19. j. Address if different from Employee					

By signing this form, you are agreeing to the terms and conditions on the reverse side.

Employee's Signature _____ Date _____

<input type="checkbox"/> 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.
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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 proclaim 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 should decide to apply for such coverage hereafter, that such subsequent application shall be subject to the applicable terms and conditions of the group services agreement/policy certificate which may require additional limitations and waiting periods. I also understand that I may be required to furnish, at my own expense, evidence of health status satisfactory to CommunityCare. I understand that CommunityCare reserves the right to deny coverage with any future application for coverage. I freely and voluntarily waive the above noted 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.

Waiver Signature _____ Date _____

HMO and POS Enrollees

A Primary Care Physician must be chosen for yourself and each family member listed as a dependent on the front of this form. Please refer to the Provider Directory to select the physician of your choice. You may select one Primary Care Physician for yourself and each family member.

ALL OTHER Enrollees

If you do not choose HMO or POS coverage (or do not live in a region where these services are available), you need not complete these sections on the front of this enrollment form pertaining to:

- Primary Care Physician's Name
- Existing Patient Information

Terms and Conditions

I hereby apply for the CommunityCare coverage for myself and any dependents listed on this form. I agree that I and my family members will abide by the provisions of coverage in the CommunityCare plan in which we are enrolled. (1) I authorize my employer to deduct any required contributions from my earnings. (2) I understand and agree that in order for HMO enrollees to receive HMO benefits, or POS enrollees to receive the in-network level of benefits, all medical services must be obtained from or authorized by my Primary Care Physician, and are subject to Utilization Review for payment of claims or receipt of services. Authorization by my Primary Care Physician for emergency medical services must be provided within 48 hours (HMO or POS) after care has been provided. (3) I authorize access to and use of my medical records and the medical records of my dependents (including records of mental health treatment and alcohol or chemical abuse treatment or prevention) for use in connection with Utilization Review, Quality Assurance, benefits or claims. (4) I understand and agree that any differences related to health coverage for HMO or POS enrollees between myself and/or my dependents and CommunityCare may be resolved by the CommunityCare Grievance Procedure, a copy of which may be obtained from the Member Services Department of CommunityCare. With regards to all other product lines, a written appeal may be filed with CommunityCare at 218 W. Sixth Street, Tulsa, OK 74119. (5) I understand that cancellation of coverage may result from any material omission or misrepresentation in answering the questions on this application, or from non-payment of dues, copayments or non-covered charges. (6) I understand that it is my responsibility to report to CommunityCare any changes in my eligibility or the eligibility of my dependents. (7) I understand and agree that no benefits shall take effect until this application is approved by CommunityCare.

By signing this enrollment form, you are giving consent for CommunityCare Managed Healthcare Plans of Oklahoma and its subsidiaries to use and disclose your protected health information (PHI) for purposes of treatment, payment and health care operations. Our receipt of your consent to this use and disclosure of your PHI is a condition of enrollment. If you do not consent to our use and disclosure of your PHI for these purposes, you will not be allowed to enroll.

In addition, by signing this form, you represent to CommunityCare that you have the ability to access information, and consent to access documents and materials related to your CommunityCare benefits, electronically via the Internet. This consent applies to the following types of documents: Summary of Benefits (Member Handbook), provider directories, benefit grids, coordination of benefits (COB) forms, mail order prescription drug applications, 24-hour nurse line information and general HMO resource materials. You may withdraw this consent annually without charge by calling our Member Services department or sending a letter to the following address: P.O. Box 3249, Tulsa, OK 74101-9953. You have the right to request and obtain a paper version of an electronic document free of charge. To access electronic documents, you will need access to the Internet and Adobe Acrobat Reader. To retain electronic documents, you may print hard copies or retain them electronically on an electronic storage device (e.g., computer hard drive, CD, DVD, etc.). Access CommunityCare's Web site at www.ccok.com.