

CommunityCare Enrollment Form

2-20 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							
Employee Name Last First Middle Initial			Social Security Number		Sex <input type="checkbox"/> M <input type="checkbox"/> F		Date of Birth		<i>Please fax completed enrollment form to (918) 594-5349 (except for new group initial enrollment)</i> Group No.					
Mailing Address			Home Phone Number ()		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated		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)				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		PPO Coverage: <input type="checkbox"/> PPO PPO Network: <input type="checkbox"/> PCC <input type="checkbox"/> PCC Select <input type="checkbox"/> PHCS (out of state)	
City		State	ZIP						Occupation <input type="checkbox"/> Hourly <input type="checkbox"/> Salaried					
Employee Primary Care Physician's Name			Existing Patient <input type="checkbox"/> Yes <input type="checkbox"/> No		PCP's Hospital or Network Affiliation			Height ft. in.			Weight lbs.	Requested effective date		

Note: Enrollment in HMO or POS requires the selection of a Primary Care Physician. You must select a PCP from the provider directory for yourself and each family member listed as a dependent on 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.)								
Spouse's Name First MI Last			Date of Birth		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number	Is your Spouse Eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Medicare # _____	
Height ft. in.	Weight lbs.	Spouse Primary Care Physician's Name		Existing Patient <input type="checkbox"/> Yes <input type="checkbox"/> No		PCP's Hospital or Network Affiliation	Address if different from Employee	
Dependent's Name First MI Last			Date of Birth		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number	Relationship <input type="checkbox"/> Son <input type="checkbox"/> Daughter Other _____	Full-time Student <input type="checkbox"/> Yes <input type="checkbox"/> No
Height ft. in.	Weight lbs.	Dependent Primary Care Physician's Name		Existing Patient <input type="checkbox"/> Yes <input type="checkbox"/> No		PCP's Hospital or Network Affiliation	Address if different from Employee	
Dependent's Name First MI Last			Date of Birth		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number	Relationship <input type="checkbox"/> Son <input type="checkbox"/> Daughter Other _____	Full-time Student <input type="checkbox"/> Yes <input type="checkbox"/> No
Height ft. in.	Weight lbs.	Dependent Primary Care Physician's Name		Existing Patient <input type="checkbox"/> Yes <input type="checkbox"/> No		PCP's Hospital or Network Affiliation	Address if different from Employee	
Dependent's Name First MI Last			Date of Birth		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number	Relationship <input type="checkbox"/> Son <input type="checkbox"/> Daughter Other _____	Full-time Student <input type="checkbox"/> Yes <input type="checkbox"/> No
Height ft. in.	Weight lbs.	Dependent Primary Care Physician's Name		Existing Patient <input type="checkbox"/> Yes <input type="checkbox"/> No		PCP's Hospital or Network Affiliation	Address if different from Employee	

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 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 _____

Evidence of Health Status

This section must be completed for the employee and any dependents to be insured. Do not leave any questions unanswered or the form will be returned for completion and may lead to a delay in processing your application.

Name and address of current family physician(s):

1. Are you or any dependent currently under any treatment or prescribed medications? Yes No
2. Have you or any dependent had unexplained weight loss or fatigue in the past 12 months? Yes No
3. Have you or any dependent ever had, been diagnosed with, counseled, consulted or treated for any of the following:
(Please circle disease or disorder.)

- a. Chest pain; disease of heart, arteries or blood vessels; high or low blood pressure? Yes No
 - b. Nervous, mental or emotional disorder; convulsions, epilepsy; unconsciousness? Yes No
 - c. Asthma or other disease of lungs or respiratory organs? Yes No
 - d. Kidney stones; disease of the kidney, bladder, male or female organs; infertility? Yes No
 - e. Cancer and/or cancerous tumor? (State type and part of body below) Yes No
 - f. Diabetes; liver or thyroid disease; enlargement of the lymph nodes? Yes No
 - g. Stomach, gall bladder, intestinal or colon disorders? Yes No
 - h. Rheumatoid arthritis or back disorders? Yes No
 - i. Phlebitis, paralysis or any other physical impairment or deformity? Yes No
 - j. Alcoholism or drug habit, or been a member of Alcoholics Anonymous? Yes No
4. Have you or any dependent been diagnosed with or received treatment for AIDS or an AIDS-related complex or other immune system disorder within the past 5 years? Yes No
 5. Have you or any dependent been hospitalized or had surgery, had any injury, illness, medical attention or medical advice or treatment during the past 5 years for any reason not already mentioned? Yes No
 6. Are you or any dependent pregnant? Yes No
If yes, have you ever had a cesarean section? Yes No
 7. Do you or any member of your immediate family applying for medical coverage smoke or have used tobacco products in the past 12 months? Yes No

Please give details to "Yes" answers from questions above (specify question number). Attach additional signed and dated sheets if necessary.

No.	Person treated	Illness or impairment & medications (if any)	Dates treated	Name/address of physician and/or hospital

Agreement

I hereby acknowledge that I have read the above statements or that they have been read to me. I declare that the answers are, to the best of my knowledge and belief, complete and true and, together with any supplements thereto, shall be the basis of any certificate of insurance issued. I understand and agree that no agent has the authority to waive a complete answer to any questions, pass on insurability, make or alter any contract, or waive any of the company's other rights or requirements. I hereby agree that no insurance will be effective until the date specified by the company on the certificate of insurance after this application has been accepted. I understand that any misrepresentation contained herein relied on by the Company may be used to reduce or deny a claim or void the contract within the contestable period if such misrepresentation materially affects the acceptance of the risk.

Authorization: I authorize any physician, medical practitioner, hospital, clinic, Veterans Administration facility, other medical or medically-related facility, insurance or reinsuring company, the Medical Information Bureau, Inc., or Consumer Reporting Agency having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or my covered dependents, and any other non-medical information of me or my covered dependents to give to CommunityCare Life & Health Insurance Company and CommunityCare HMO or their legal representative any and all such information.

I understand the information obtained by use of the authorization may be used by CommunityCare Life & Health Insurance Company and CommunityCare HMO to determine eligibility for insurance and eligibility for benefits under an existing policy. Any information obtained will not be released by the insurer to any person or organization except to reinsuring companies, the Medical Information Bureau, Inc., or other persons or organizations performing business or legal services in connection with my application, claim or as may be otherwise lawfully required, or as I may further authorize. I know that I may request to receive a copy of this authorization. I agree that a photographic copy of this authorization shall be as valid as the original. I agree that this authorization shall be valid for three years from the date shown below.

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.

Employee's Signature _____

Date _____