



CHANGE FORM

Please fax completed change form to (918) 594-5349

CHECK ONE

- | | |
|------------------------------------|------------------------------|
| <input type="checkbox"/> HMO | <input type="checkbox"/> HRA |
| <input type="checkbox"/> IDEA | <input type="checkbox"/> POS |
| <input type="checkbox"/> IDEA Plus | <input type="checkbox"/> PPO |

Effective Date of Change _____

CommunityCare I.D. Number		Employer Name		Group Number	
Employee Name Last		First		Middle Initial	
Social Security Number		Street Address		City	
State		ZIP code		Home Telephone	
()		()		Work Telephone	
Extension					

Change as indicated:

- Name Change Address/Phone Change
 List former name: _____

If a name change is being made as a result of marriage and the employee does not request the addition of any new eligible dependent(s) at this time, this form shall serve as waiver of dependent coverage and the procedure for late enrollment of dependent(s) shall apply to any subsequent request for dependent coverage.

Employee Signature _____ Date _____

Request to Add Dependent(s)

Please list all dependent(s) for whom you are requesting coverage.

Name	Relationship	Social Security Number	Date of Birth	Sex	PCP Selection	Established Patient?

Does this dependent(s) have other coverage? If so, please list health insurance carrier(s): _____

Reason for change: _____ Date of change: _____

Request to Drop Coverage

Reason for Change

Under the coverages issued to my employer, I do not wish coverage for: <input type="checkbox"/> Myself and my dependent(s) (if any) <input type="checkbox"/> All dependents <input type="checkbox"/> My dependent(s) - child(ren) <input type="checkbox"/> Spouse only List dependent(s) - child(ren) name(s): _____ _____ _____	<input type="checkbox"/> Disenrollment (changing health insurance carriers) <input type="checkbox"/> Terminating employment <input type="checkbox"/> Divorce <input type="checkbox"/> Other: _____
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Change of Primary Care Physician

Please note that the effective date of the PCP change will be on the first day of the month if the request is received before the 15th of the previous month.

Last Name	First Name	New PCP	Reason for Change

*All PCP changes must be approved by CommunityCare before becoming effective. All existing referrals or precertifications made by your former Primary Care Physician are canceled as of the effective date of the change to your new Primary Care Physician. Your new Primary Care Physician is responsible for your care as of the effective date.

Employee Signature _____ Date _____