



CHANGE FORM

Fax form to (918) 594-5349 or email to communitycareenrollment@ccok.com.

Effective Date of Change _____

Open Enrollment Plan Changes <u>ONLY</u>	
Changing from:	Changing to:
<input type="checkbox"/> HMO <input type="checkbox"/> Classic Network <input type="checkbox"/> Select Network <input type="checkbox"/> Standard Network	<input type="checkbox"/> HMO <input type="checkbox"/> Classic Network <input type="checkbox"/> Select Network <input type="checkbox"/> Standard Network
<input type="checkbox"/> PPO <input type="checkbox"/> Select Network <input type="checkbox"/> Standard Network	<input type="checkbox"/> PPO <input type="checkbox"/> Select Network <input type="checkbox"/> Standard Network
<input type="checkbox"/> POS <input type="checkbox"/> Select Network <input type="checkbox"/> Standard Network	<input type="checkbox"/> POS <input type="checkbox"/> Select Network <input type="checkbox"/> Standard Network

REMINDER: If you are making a change outside of your open enrollment period, please include the appropriate documentation with this form, such as a copy of a marriage certificate, divorce decree, certificate of creditable coverage from prior carrier (for loss of coverage), etc.

CommunityCare ID Number		Employer Name		Group Number	
Employee Name Last		First		Middle Initial	
Social Security Number		Street Address		City	
State		ZIP code		Home Telephone	
Work Telephone		Marital Status		<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated	

Change as indicated: Name Change *List former name:* _____
 Address/Phone Change *List former address/phone:* _____

Name Change as a Result of Marriage
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. *Note: Outside of open enrollment, a copy of your marriage certificate is required with this form.*

Employee Signature _____ Date _____

Request to Add Dependent(s): Please list all dependent(s) for whom you are requesting coverage. Attach a certificate of creditable coverage if outside open enrollment period.

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

Does this dependent(s) have a different address? If so, please list the address: _____
Does this dependent(s) have other coverage? If so, please list health insurance carrier(s): _____
Reason for change: _____ Date of change: _____

<p>Request to Drop Coverage</p> <p>Under the coverages issued to my employer, I do not wish coverage for:</p> <input type="checkbox"/> Myself and my dependent(s) (if any) <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) <i>List name(s):</i> _____	<p>Reason for Change</p> <input type="checkbox"/> Disenrollment (<i>changing health insurance carriers, reduction in hours, voluntary disenrollment, etc.</i>) <input type="checkbox"/> Terminating employment – Please select one: <input type="checkbox"/> Voluntary <input type="checkbox"/> Involuntary <input type="checkbox"/> Involuntary due to misconduct <input type="checkbox"/> Divorce (<i>outside of open enrollment, please include copy of divorce decree</i>) <input type="checkbox"/> Other: _____
--	---

<input type="checkbox"/> Select or Change Primary Care Physician			<input type="checkbox"/> Change Hospital Network	
Last Name	First Name	New PCP	PCP's Hospital Network	Established Patient?

**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 _____
Employer Signature (if employee not present) _____