CHANGE FORM

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

Effective Date of Change ______________

Open Enrollment Plan Changes ONLY

Changing from:		Changing to:	
❑HMO	❑Classic Network ❑Select Network ❑Standard Network	❑HMO	❑Classic Network ❑Select Network ❑Standard Network
❑PPO	❑Select Network ❑Standard Network	❑PPO	❑Select Network ❑Standard Network
❑POS	❑Select Network ❑Standard Network	❑POS	❑Select Network ❑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 ❑Single ❑Married ❑Divorced ❑Widowed ❑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: ______________

Request to Drop Coverage

Under the coverages issued to my employer, I do not wish coverage for:

❑ **Myself and my dependent(s)** ***(if any)***

❑ Spouse

❑ Child(ren) *List name(s):* ______________________________

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Reason for Change

❑ Disenrollment *(changing health insurance carriers, reduction in hours, voluntary disenrollment, etc.)*

❑ Terminating employment – Please select one:

❑ Voluntary ❑ Involuntary ❑ Involuntary due to misconduct

❑ Divorce *(outside of open enrollment, please include copy of divorce decree)*

❑ Other: ______________________________

❑ Select or Change Primary Care Physician

❑ 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)*** ______________________________