CommunityCare

SMALL GROUP ENROLLMENT FORM

Please check one of the following: ❑ Applying for Coverage ❑ Waiving (Declining) Coverage – *See "Waiver" Section below*

FOR EMPLOYER USE

Please fax completed enrollment form to (918) 594-5349 (except for new group initial enrollment)

1. Employee Name Last First Middle Initial			2. Social Security Number		3. Gender ❑ M ❑ F	4. Date of Birth		Group No.
5. Mailing Address		6. Home Phone #	7. Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Legally Separated	8. Apply for: ❑ Self ❑ Self & Spouse ❑ Self & 1 Child ❑ Self & Children ❑ Self & Family ❑ None (Waiver)	9. a. HMO Coverage: ❑ HMO ❑ IDEA Plus ❑ IDEA ❑ HRA HMO Network: 1. HMO Select 2. HMO Standard HMO Classic	9. b. PPO Coverage: ❑ PPO PPO Network: 3. PPO Select 4. PPO Standard PHCS *(out of state)*	9. c. Other Coverage: ❑ COBRA ❑ Retiree	Div. No. / Employment Date *(full-time)*
10. City	11. State	12. ZIP						Employer/Company Name
13. a. Occupation	13. b. ❑ Hourly ❑ Salaried	14. Work Phone #						
15. a. Employee Primary Care Physician's Name		15. b. Existing Patient ❑ Yes ❑ No	15. c. PCP's Hospital or Network Affiliation		15. d. E-mail Address			Requested effective date

Notice: Enrollment in HMO requires the selection of a Primary Care Physician. All Employees should refer to instructions on the reverse side of this form.

Does anyone enrolling have other coverage? ❑ No ❑ Yes If yes, please answer the following:

Name of Person Covered by other Insurance	Insurance ID number	Policyholder's name	Name of other insurance company	Other insurance company phone number

Does the other coverage include pharmacy benefits? ❑ No ❑ Yes

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 ❑ M ❑ F	16. d. Social Security Number	16. e. Is your Spouse eligible for Medicare? ❑ Yes ❑ No If yes, Medicare # _____	
16. f. Spouse Primary Care Physician's Name	16. g. Existing Patient ❑ Yes ❑ 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 ❑ M ❑ F	17. d. Social Security Number	17. e. Relationship ❑ Son ❑ Daughter Other_____	
17. f. Dependent Primary Care Physician's Name	17. g. Existing Patient ❑ Yes ❑ No	17. h. PCP's Hospital or Network Affiliation		17. i. Address if different from Employee	17. j. Disabled ❑ Yes ❑ No
18. a. Dependent's Name First MI Last	18. b. Date of Birth	18. c. Sex ❑ M ❑ F	18. d. Social Security Number	18. e. Relationship ❑ Son ❑ Daughter Other_____	
18. f. Dependent Primary Care Physician's Name	18. g. Existing Patient ❑ Yes ❑ No	18. h. PCP's Hospital or Network Affiliation		18. i. Address if different from Employee	18. j. Disabled ❑ Yes ❑ No
19. a. Dependent's Name First MI Last	19. b. Date of Birth	19. c. Sex ❑ M ❑ F	19. d. Social Security Number	19. e. Relationship ❑ Son ❑ Daughter Other_____	
19. f. Dependent Primary Care Physician's Name	19. g. Existing Patient ❑ Yes ❑ No	19. h. PCP's Hospital or Network Affiliation		19. i. Address if different from Employee	19. j. Disabled ❑ Yes ❑ No

❑ 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 affirm 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 apply for such coverage hereafter, my application shall be subject to the applicable terms and conditions of the group services agreement/policy certificate which may impose additional limitations and waiting periods. I freely and voluntarily waive my employer's 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.

➔Employee's Signature *(Terms and conditions are on reverse side)*_____ Date _____

HMO Enrollees

A Primary Care Physician must be chosen for you 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 you and each family member.

ALL OTHER Enrollees

If you do not choose HMO coverage (or do not live in a region where these services are available), you do not need to complete the following 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 me and any dependents listed on this form. I agree that I and my family members will abide by all terms of coverage governing the CommunityCare plan in which we are enrolled. I authorize my employer to deduct any required contributions from my earnings. I understand that coverage for me and my dependents may be cancelled as a result of any material omission or misrepresentation in answering the questions on this application, or from non-payment of premiums or cost-sharing amounts due under the terms of our plan. I understand that it is my responsibility to report to CommunityCare any changes in my eligibility or the eligibility of my dependents. 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 (HMO Member Handbook and/or PPO Certificate), provider directories, benefit summaries, coordination of benefits (COB) forms, mail order prescription drug applications, 24-hour nurse line information and general 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 website at www.ccok.com.