CareConnect℠

Individual Application

EPO Plan Selection—Effective Date: ____/____/____

☐ Standard Bronze EPO ☐ Standard Silver EPO ☐ Standard Gold EPO ☐ Standard Platinum EPO ☐ Tradition Platinum 30 HRx ☐ Tradition Platinum 30 LRx

☐ Tradition Gold 30/50 HRx ☐ Tradition Gold 30/50 LRx ☐ Tradition Silver 40/60 HRx ☐ Tradition Silver 40/60 LRx ☐ Value Silver 100% ☐ Value Gold 100%

☐ Value Platinum 100% ☐ Bronze HSA 70% ☐ Catastrophic ☐ Other: _____

☐ **Special Enrollment Period:** ____/____/____ (check triggering event below and attach proof)

☐ Loss of minimum essential coverage ☐ Marriage/divorce/birth/adoption/foster care ☐ Change in eligibility for financial assistance

☐ Dependent attained age 26 and lost coverage ☐ Access to new plan due to permanent move ☐ Enrollment error by the Marketplace or other entity providing enrollment assistance

☐ Other: _____

Details *(• required fields)*	**Applicant**	**Spouse**	**Child**	**Child**	**Child**
• **Last Name:**					
• **First Name:**					
• **Social Security Number:**					
• **DOB: (MM/DD/YYYY)**	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____
• **Street Address:**					
• **City, State, Zip:**					
• **Phone Number:**					
• **E-mail Address:** (For office use only.)					
• **Gender**	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
PCP Name:					
PCP ID Number:					
Prior Carrier:					
• **Policy Number:**					
• **Start Date:**	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____
• **End Date:**	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____

(Continued on reverse side.)

Individual Application (continued)

CareConnect

Please complete if you have or expect to have additional medical coverage. *(• required fields)*

Coordination of Benefits		Applicant	Spouse	Child	Child	Child
• **Medicare Coverage** (Select box and write date)		☐ Part A ___/___/___ ☐ Part B ___/___/___ ☐ Part D ___/___/___ ☐ Medicare Part D Eligible ___/___/___	☐ Part A ___/___/___ ☐ Part B ___/___/___ ☐ Part D ___/___/___ ☐ Medicare Part D Eligible ___/___/___	☐ Part A ___/___/___ ☐ Part B ___/___/___ ☐ Part D ___/___/___ ☐ Medicare Part D Eligible ___/___/___	☐ Part A ___/___/___ ☐ Part B ___/___/___ ☐ Part D ___/___/___ ☐ Medicare Part D Eligible ___/___/___	☐ Part A ___/___/___ ☐ Part B ___/___/___ ☐ Part D ___/___/___ ☐ Medicare Part D Eligible ___/___/___
• **Medicaid Coverage**	Carrier: Policy Number: Start Date: End Date:	___ ___ ___/___/___ ___/___/___	___ ___ ___/___/___ ___/___/___	___ ___ ___/___/___ ___/___/___	___ ___ ___/___/___ ___/___/___	___ ___ ___/___/___ ___/___/___
• **Pharmacy**	Carrier: Policy Number: Start Date: End Date:	___ ___ ___/___/___ ___/___/___	___ ___ ___/___/___ ___/___/___	___ ___ ___/___/___ ___/___/___	___ ___ ___/___/___ ___/___/___	___ ___ ___/___/___ ___/___/___
• **Medical**	Carrier: Policy Number: Start Date: End Date:	___ ___ ___/___/___ ___/___/___	___ ___ ___/___/___ ___/___/___	___ ___ ___/___/___ ___/___/___	___ ___ ___/___/___ ___/___/___	___ ___ ___/___/___ ___/___/___

• Have you obtained stand-alone dental coverage that provides a pediatric dental essential health benefit through a NYSOH-certified stand-alone dental plan offered outside the NYSOH? ☐ Yes ☐ No

• If you answered "yes", please provide the name of the company issuing the stand-alone dental coverage. ___

If you answered "no", we will provide you coverage of the pediatric dental essential health benefit.

Broker/GA Information (if applicable)

	Broker	Co-Broker	General Agent
Name of Payee	Jay Z. Gerlitz & Associates, Inc.	N/A	N/A
CareConnect's Broker and/or General Agency Code	1642		
Payee's SS# or Federal Tax ID #	13-3805732		
Commission Split	100%		
Sales Representative	Travis Creed		

The undersigned hereby requests that North Shore-LIJ CareConnect Insurance Company, Inc. accept the Broker or Agent named above as an authorized person for purposes of processing any enrolment transactions for my North Shore-LIJ CareConnect Insurance Company, Inc. policy. This authorization shall be effective immediately and shall remain in place until it is expressly revoked by me in writing. Further, I agree that I will be bound by the actions performed by the herein-named Broker or Agent pursuant to this Consent Form. Additionally, I agree that this Consent Form does not authorize anyone to receive individually identifiable health information about me. I acknowledge that I must notify North Shore-LIJ CareConnect Insurance Company, Inc. in writing to void this agreement in the event of a change in my Broker of Record.
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed $5,000 dollars and the stated value of the claim for each violation.

___
Print name of insured or authorized representative

___ ___/___/___
Signature of insured or authorized representative Date

___
Description of authorized representative's authority (e.g., power of attorney, guardianship order) *Documentation must be made available at CareConnect's request.*

North Shore-LIJ CareConnect Insurance Company, Inc.
Attention: Group Enrollment Department
2200 Northern Boulevard, Suite 104, East Hills, NY 11548
855-706-7545 CareConnect.com