North Shore LIJ CareConnect | Insuring better health

Small Group Member Application

MAILING ADDRESS:
North Shore-LIJ Insurance Company Inc.
Attention: Enrollment Department
145 Community Drive, Great Neck, NY 11021
855-706-7545 www.nslijcareconnect.com

EPO Plan Selection

☐ Bronze ☐ Silver ☐ Gold ☐ Platinum
☐ Copay ☐ Cost Share ☐ HSA

Details	Applicant		Spouse		Child		Child	
Last Name:								
First Name:								
Social Security Number:								
DOB: (MM/DD/YYYY)	_____/_____/_____		_____/_____/_____		_____/_____/_____		_____/_____/_____	
Street Address:								
City, State, Zip:								
Gender/Disability:	☐ Male ☐ Female	☐ Disabled	☐ Male ☐ Female	☐ Disabled	☐ Male ☐ Female	☐ Disabled	☐ Male ☐ Female	☐ Disabled
PCP Name:								
PCP ID Number:								
Additional Dependent Info:	Applicant		☐ Domestic Partner		☐ Young Adult		☐ Young Adult	
Prior Carrier:								
Policy Number:								
Start Date:	_____/_____/_____		_____/_____/_____		_____/_____/_____		_____/_____/_____	
End Date:	_____/_____/_____		_____/_____/_____		_____/_____/_____		_____/_____/_____	

(Continued)

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Small Group Member Application (continued)

Coordination of Benefits		Applicant	Spouse	Child	Child
Medicare Coverage (Select box and write date)		☐ Part A _____/_____/_____ ☐ Part B _____/_____/_____ ☐ Part D _____/_____/_____	☐ Part A _____/_____/_____ ☐ Part B _____/_____/_____ ☐ Part D _____/_____/_____	☐ Part A _____/_____/_____ ☐ Part B _____/_____/_____ ☐ Part D _____/_____/_____	☐ Part A _____/_____/_____ ☐ Part B _____/_____/_____ ☐ Part D _____/_____/_____
Pharmacy	Carrier:				
	Policy Number:				
	Start Date:	_____/_____/_____	_____/_____/_____	_____/_____/_____	_____/_____/_____
	End Date:	_____/_____/_____	_____/_____/_____	_____/_____/_____	_____/_____/_____
Medical	Carrier:				
	Policy Number:				
	Start Date:	_____/_____/_____	_____/_____/_____	_____/_____/_____	_____/_____/_____
	End Date:	_____/_____/_____	_____/_____/_____	_____/_____/_____	_____/_____/_____
Group Name		Billing Group	DOH (MM/DD/YYYY) _____/_____/_____	Effective Date _____/_____/_____	Occupation
Group Number		COBRA/YA/SC Qualifying Event	Event Date _____/_____/_____	Employer Signature	Date _____/_____/_____

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.

____ ________/________/________

Employee Signature Date