

CBIA HEALTH CONNECTIONS **Enrollment/Change Form**

1. EMPLOYER NAME: _____ Employer Group Number: _____ Division: _____

Enrollment <input type="checkbox"/> <input type="checkbox"/> New Group <input type="checkbox"/> New Employee <input type="checkbox"/> Existing Employee Newly Eligible <input type="checkbox"/> Existing Employee: SPECIAL ENROLLMENT <input type="checkbox"/> Rehired/Reinstatement of Coverage <input type="checkbox"/> Open Enrollment (A completed Family Health Statement is required for all of the above)	<div style="border: 1px solid black; padding: 2px; text-align: center;">Group of 3-50 ees</div> Change (indicate reason) <input type="checkbox"/> <input type="checkbox"/> Add Dependent (provide Date of Event) _____ Marriage _____ Birth _____ Adoption _____ Loss of Other Coverage (attach Cert. of Creditable Coverage) <input type="checkbox"/> Remove Dependents <input type="checkbox"/> Other _____ <input type="checkbox"/> Open enrollment	Termination of Coverage <input type="checkbox"/> <input type="checkbox"/> Canceling All Coverage Termination Date _____ Cancel <u>only the following</u> coverages: <input type="checkbox"/> Med. <input type="checkbox"/> Dental <input type="checkbox"/> STD <input type="checkbox"/> LTD <input type="checkbox"/> Supplemental Life	Continuation-of-Coverage (Attach election form) <input type="checkbox"/> Date & Type of Qualifying Event _____ Termination of Employment/Loss of Eligibility _____ Death of Covered Employee _____ Divorce or Legal Separation _____ Dependent Child Limiting Age _____ Loss of Dependent Coverage When Employee Became Entitled to Medicare Effective date of continuation _____
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2. EMPLOYEE INFORMATION - PLEASE PRINT CLEARLY AND COMPLETE THE ENTIRE FORM Rev 03-03-03 3-50

Employee Name	Home Telephone ()	Employee date of: Hire/Rehire/Retirement _____	Are you: <input type="checkbox"/> Actively at work <input type="checkbox"/> COBRA <input type="checkbox"/> Retired # of hours worked per week: _____
Street Address	Apt #: _____	Work Telephone ()	Do you or any dependents have Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you or any dependents have Medicare Part A ___ Part B ___ Both _____
City, State, ZIP	Marital status <input type="checkbox"/> Single <input type="checkbox"/> Married	Part-time to Full-time Employment Date: _____ Effective Date: _____	

3. LIST YOURSELF AND ALL ELIGIBLE DEPENDENTS TO BE ENROLLED OR CHANGED UNDER YOUR COVERAGE. REMEMBER, EACH PERSON **MUST SELECT A PRIMARY CARE PHYSICIAN/NUMBER.**

Name (Last Name, First Name, Middle Initial)	Sex	Full-time Student	Birth date MM/DD/YY	Social Security #	You must fill in your PCP Number and his or her Last Name	Prev. Seen
Employee	<input type="checkbox"/> M <input type="checkbox"/> F	N/A		- -		Y / N
Spouse	<input type="checkbox"/> M <input type="checkbox"/> F	N/A		- -		Y / N
Child	<input type="checkbox"/> M <input type="checkbox"/> F	Y* / N		- -		Y / N
Child	<input type="checkbox"/> M <input type="checkbox"/> F	Y* / N		- -		Y / N
Child	<input type="checkbox"/> M <input type="checkbox"/> F	Y* / N		- -		Y / N

Are you or your spouse entitled to Social Security Disability? Yes No Are any of the dependent children listed above eligible for coverage as a result of an incapacity? Yes No
 *If dependent child(ren) listed are 19 (the limiting age) and attend school on a full-time basis. **Attach official (raised seal) proof of full-time student status for current/upcoming semester. See reverse for CTCare requirements.**
 Are you or any of your dependents covered by another health plan? Yes No If yes, list carrier and plan number: _____

4. MEDICAL (choose 1 health plan & plan of benefit) Coverage Level: Medical <input type="checkbox"/> Waive medical <input type="checkbox"/> Empl. <input type="checkbox"/> Empl. + Spouse <input type="checkbox"/> Empl. + Child(ren) <input type="checkbox"/> Family <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> In State Coverage Health Plan <input type="checkbox"/> Aetna <input type="checkbox"/> CIGNA <input type="checkbox"/> CTCare <input type="checkbox"/> Health Net <input type="checkbox"/> Oxford <input type="checkbox"/> Anthem BC&BS Medicare Addl. form reqd. for ea. elig. member Plan of Benefits (In state) <input type="checkbox"/> HMO Preferred (\$10) <input type="checkbox"/> HMO Standard (\$20) <input type="checkbox"/> HMO Value (\$30) <input type="checkbox"/> POS Preferred (\$10) <input type="checkbox"/> POS Standard (\$20) <input type="checkbox"/> POS Value (\$30) <input type="checkbox"/> Open Access (OA) (\$10) (excl. Aetna & CIGNA) </div> <div style="width: 45%;"> Out of State Coverage ConnectiCare (MA) <input type="checkbox"/> POS (\$15) <input type="checkbox"/> HMO (\$15) <input type="checkbox"/> Open Access (OA) (\$10) Health Net (NY, NJ & PA) Oxford (NY/NJ/PA) <input type="checkbox"/> HMO Preferred (\$10) <input type="checkbox"/> HMO Standard (\$20) <input type="checkbox"/> HMO Value (\$30) <input type="checkbox"/> POS Preferred (\$10) <input type="checkbox"/> POS Standard (\$20) <input type="checkbox"/> POS Value (\$30) <input type="checkbox"/> POS Preferred OA (\$10) <input type="checkbox"/> Oxford USA (outside CT) </div> </div>	5. DENTAL-AETNA Coverage Level: Dental <input type="checkbox"/> Waive dental <input type="checkbox"/> Employee <input type="checkbox"/> Empl. + Spouse <input type="checkbox"/> Empl. + Child(ren) <input type="checkbox"/> Family	6. LIFE/DISABILITY - THE HARTFORD <input type="checkbox"/> Life (Required) Amount \$ _____ <input type="checkbox"/> AD&D Amount \$ _____ <input type="checkbox"/> Dependent Life <input type="checkbox"/> STD <input type="checkbox"/> LTD Current annual salary: \$ _____	8. AUTHORIZATION AND ACCEPTANCE I hereby apply for the health plan and benefit plan selected, understanding all benefits and coverage as specified in the enrollment brochure and agreeing to abide by all the rules and regulations therein specified. I authorize deductions from my earnings of the required contributions, if any, toward the cost of the coverage. I authorize any provider, insurance company, employer or organization to release any information, on me or my dependents, regarding the medical, dental, mental, confidential HIV related information, alcohol or drug abuse history, treatment or benefits payable, including disability or employment-related information, to the Plan Administrator or its authorized agent for the purpose of validating and determining benefits payable in connection with this Plan. The information provided is true and correct to the best of my knowledge. I understand my coverage and benefits may be affected by failure to provide complete and accurate information. Important! The employee's and employer's signatures are required before submitting this application. CBIA reserves the right to deny or delay enrollment if information or required signatures are missing from this enrollment form. Employee Signature _____ Date Signed _____ Employer Signature _____ Date Signed _____
7. LIFE INSURANCE BENEFICIARY INFORMATION To the EMPLOYER: This is the <u>only</u> record of an employee's beneficiary designation. Please retain a copy and submit it at the time of request for death benefits. This form should also be used for any changes in beneficiary designation. Please record the appropriate date. Beneficiary Name: Last, First, MI: _____ Relationship of Beneficiary: _____ Date: _____			

CBIA HEALTH CONNECTIONS

T H E P O W E R O F C H O I C E

Please read the following

- Please complete all items 1-8 to avoid delays in processing
- If you are waiving health care coverage and wish to have life insurance if applicable, please complete all sections indicating the amount of life insurance selected and your Beneficiary.
- If you or one of your dependents is enrolling in our Medicare Primary plan, you must complete both this form and the Anthem Blue Cross & Blue Shield enrollment form. Both forms must be completed in full, signed and dated to avoid delays in coverage.
- Both your signature and date and your employer's signature and date must be on the form.
- ConnectiCare requires letter from registrar's office as acceptable proof of full time student status.
- Oxford USA excludes coverage in: Connecticut, Idaho, Maine, Mississippi, Montana, New Jersey, Oklahoma, South Dakota and Wyoming. In New York, the following counties have coverage: Manhattan, The Bronx, Brooklyn, Staten Island, Queens, Rockland, Nassau, Suffolk, Westchester, Dutchess, Orange, Putnam, Richmond, Kings County. Upstate regions covered by Oxford USA

Thank you for selecting coverage through your employer's CBIA Health Connections Group insurance plan.