ConnectiCare

Small Group Fixed Funding Solutions Enrollment/Change Form

ConnectiCare Small Group Administration
175 Scott Swamp Rd., Farmington, CT 06032
Fax: 860-678-5281

Please print clearly.
Complete in full using ballpoint pen.

EMPLOYER: If enrolling under a group plan, form cannot be processed without this information. Non-Group Enrollees, Skip to next section

Group Name	Employee Work Location	Group Number

Date of Hire (mm/dd/yy)	Hours Per Week	Coverage Effective Date (mm/dd/yy)	Coverage End Date (mm/dd/yy)	COBRA ☐ Yes ☐ No COBRA Start Date (mm/dd/yy) / COBRA End Date (mm/dd/yy)	Length of coverage: ☐ 18 months ☐ Other

Employer Signature	Title	Date

SUBSCRIBER/EMPLOYEE: Complete the following sections, sign at bottom, and read information on reverse side.

Please check appropriate item: ☐ New Enrollment ☐ Terminate Enrollment ☐ Add Dependent ☐ Remove Dependent ☐ Change Plan ☐ COBRA Election
☐ Other (Name change, address change, etc. Indicate reason for change.) _____

First Name	Middle Name	Last Name

Street Address	City	State	ZIP Code

Primary Phone Number ☐ Home ☐ Cell ☐ Work	Secondary Phone Number ☐ Home ☐ Cell ☐ Work	Email Address	Primary Language (optional)

Marital Status: ☐ Single ☐ Married/Civil Union ☐ Domestic Partner ☐ Legally Separated ☐ Separated ☐ Divorced ☐ Widowed

2024 PLANS

HSA Compatible Plans:

☐ FlexPOS HSA $6800 40%
☐ FlexPOS HSA $5000 50%
☐ FlexPOS HSA $3200 25%

Copay/Coinsurance Plans:

☐ FlexPOS $40/$80 $5000 20%
☐ FlexPOS $35/$50 $4000 35%
☐ FlexPOS $40/$80 $2750 20%
☐ FlexPOS $30/$50 $3500 20%
☐ FlexPOS $30/$50 $2000
☐ FlexPOS $30/$45 $500

Subscriber/Dependents: First Name/Middle Initial/Last Name	Add	Delete	Social Security Number (required)	Sex	Date of Birth (mm/dd/yy)	Primary Care Provider	ConnectiCare Provider ID Number (optional)	Existing Patient
Subscriber/Employee	☐	☐		☐ M ☐ F				☐ Yes ☐ No
Spouse/Civil Union/Domestic Partner	☐	☐		☐ M ☐ F				☐ Yes ☐ No
Dependent 1	☐	☐		☐ M ☐ F				☐ Yes ☐ No
Dependent 2	☐	☐		☐ M ☐ F				☐ Yes ☐ No
Dependent 3	☐	☐		☐ M ☐ F				☐ Yes ☐ No

Race/Ethnicity (Required): This information is designed for the purpose of data collection and will not be used to determine eligibility, rating, or claim payment.

Employee:
Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino **Race:** ☐ White ☐ Black/African American ☐ Asian ☐ Amer. Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Other: _____

Spouse/Civil Union/Domestic Partner:
Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino **Race:** ☐ White ☐ Black/African American ☐ Asian ☐ Amer. Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Other: _____

Dependent 1:
Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino **Race:** ☐ White ☐ Black/African American ☐ Asian ☐ Amer. Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Other: _____

Dependent 2:
Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino **Race:** ☐ White ☐ Black/African American ☐ Asian ☐ Amer. Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Other: _____

Dependent 3:
Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino **Race:** ☐ White ☐ Black/African American ☐ Asian ☐ Amer. Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Other: _____

☐ Check if enrolling a disabled dependent age 26 and over. Please complete the Disabled Dependent Application Form and return with your enrollment.

Other health care coverage: Will you have other health insurance in addition to this ConnectiCare plan, under a Group, HMO, or Medicare plan? ☐ Yes ☐ No

If yes, name of person covered	Employer	
Insurance Co. Name and Address (Please attach a copy of your group medical insurance card.)	Policy Number	Medicare (Please attach a copy of your Medicare card.) ☐ Part A ☐ Part B ☐ Retired

Important: By signing here, you are indicating that you have read and understand the information on the front **and back** of this form. This authorization is valid as long as you are enrolled in a ConnectiCare health plan, and for one year after enrollment in the plan ends. To the best of my knowledge and belief, I certify that the information supplied in the form is correct. I agree to the consent on the reverse side of this form. I understand that the phone numbers I provided on this application may be used by ConnectiCare or any of its contracted parties to contact me about my account, the provision of services to me, or my health benefit plan or related programs.

▶ Subscriber/Employee's Signature _____ Date _____

Print Reset Form

IMPORTANT: EMPLOYEE/MEMBER CONSENT

On my behalf and on behalf of my spouse and/or dependent(s), I hereby authorize any doctor, hospital, provider, insurer, ConnectiCare Insurance Company, Inc. (CICI) or a CICI-affili e, or other organization or person having records, data or information concerning health history or medical insurance for me or my family member(s), including but not limited to information concerning mental health, alcohol/substance abuse or HIV or AIDS-related conditions, to transfer to any person or company such records, data or information as may be required for the purpose of providing treatment, paying claims, and performing other operations to administer my Benefit Plan. I unde stand that CICI's privacy notice contains a more complete description of the purposes for which information about me and my dependent(s) may be used or disclosed and that I have a right to review the privacy notice prior to signing this consent. I understand that CICI may change such notice at any time but will provide me a copy of any amended notice. I understand that I have a right to request restrictions on how information about me and my dependent(s) may be used or disclosed to carry out the plan administration purposes and that CICI is not required to agree to the requested restrictions. I understand that this authorization is valid for the term of my and my dependents' coverage under the Plan. I understand that I can revoke this authorization (but will be terminated from the Plan) at any time by giving written notice to CICI as long as CICI or others have not taken action relying on this authorization. I acknowledge that I have retained a copy of this authorization. I authorize payroll deduction, if any, for the coverage I have elected.

I understand that 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, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime punishable by penalties, imprisonment, and restitution depending on applicable laws.

ConnectiCare collects race/ethnicity data solely for the purposes of developing quality improvement programs, education, training, and marketing purposes. This data will not be used for determining eligibility, premium rate, or claim payment.

INSTRUCTIONS: DID YOU REMEMBER TO...

- ☐ **Print clearly, complete all sections, and sign at the bottom of page 1?**
- ☐ **Select your primary care provider and include the ConnectiCare Provider ID number? (Can be found in the Provider Directory or on our website.)**
- ☐ **Attach a copy of your Medicare card if you are enrolled in Medicare?**
- ☐ **Attach a copy of your group medical insurance card if you have other coverage?**
- ☐ **Insert Social Security number for each dependent?**
- ☐ **Retain a copy of this form for your records?**