ConnectiCare

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

Small Group Fixed Funding Solutions Enrollment/Change Form

Please print clearly. Complete all fields.

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/Continuation: ☐ 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

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

2024 PLANS

HSA-Compatible Plans	Copay/Coinsurance Plans
☐ FlexPOS HSA $6,800 40% ☐ FlexPOS HSA $5000 50% ☐ FlexPOS HSA $3,300 25%	☐ FlexPOS $40/$80 $5,000 20% ☐ FlexPOS $40/$80 $2,750 20% ☐ FlexPOS $30/$50 $3,500 20% ☐ FlexPOS $35/$50 $4,000 35% ☐ FlexPOS $30/$50 $2,000 ☐ FlexPOS $30/$45 $500

SUBSCRIBER/DEPENDENTS	Add	Remove	Social Security Number (required)	Birth Sex: What sex were you assigned at birth?	Gender Identity: What is your current gender identity?	Date of Birth (mm/dd/yy)	Primary Care Provider
Subscriber/Employee (First Name/Middle Initial/Last Name)	☐	☐		☐ M ☐ F ☐ Gender X ☐ Unknown	☐ M ☐ F ☐ Transgender male/female-to-male (FTM) ☐ Transgender female/male-to-female (MTF) ☐ Non-binary/gender X/genderqueer or third gender ☐ Other: Prefer to self describe ☐ Choose not to disclose		
Spouse/Civil Union/Domestic Partner (First Name/Middle Initial/Last Name)	☐	☐		☐ M ☐ F ☐ Gender X ☐ Unknown	☐ M ☐ F ☐ Transgender male/female-to-male (FTM) ☐ Transgender female/male-to-female (MTF) ☐ Non-binary/gender X/genderqueer or third gender ☐ Other: Prefer to self describe ☐ Choose not to disclose		
Dependent 1 (First Name/Middle Initial/Last Name)	☐	☐		☐ M ☐ F ☐ Gender X ☐ Unknown	☐ M ☐ F ☐ Transgender male/female-to-male (FTM) ☐ Transgender female/male-to-female (MTF) ☐ Non-binary/gender X/genderqueer or third gender ☐ Other: Prefer to self describe ☐ Choose not to disclose		
Dependent 2 (First Name/Middle Initial/Last Name)	☐	☐		☐ M ☐ F ☐ Gender X ☐ Unknown	☐ M ☐ F ☐ Transgender male/female-to-male (FTM) ☐ Transgender female/male-to-female (MTF) ☐ Non-binary/gender X/genderqueer or third gender ☐ Other: Prefer to self describe ☐ Choose not to disclose		
Dependent 3 (First Name/Middle Initial/Last Name)	☐	☐		☐ M ☐ F ☐ Gender X ☐ Unknown	☐ M ☐ F ☐ Transgender male/female-to-male (FTM) ☐ Transgender female/male-to-female (MTF) ☐ Non-binary/gender X/genderqueer or third gender ☐ Other: Prefer to self describe ☐ Choose not to disclose		

continued

MEMBER DEMOGRAPHIC DATA (Required) This information is designed for the purpose of data collection and will not be used to determine eligibility, rating, or claim payment.

Employee

Pronouns: What are your pronouns? ☐ He/him ☐ She/her ☐ They/them ☐ Choose not to disclose

Sexual Orientation: Which of the following best describes you? ☐ Straight or heterosexual ☐ Lesbian or gay ☐ Bisexual ☐ Queer, pansexual, and/or questioning ☐ Don't Know ☐ Other option not specified (something else) ☐ Choose not to disclose

Accessible Format: ☐ Not applicable ☐ B - Braille ☐ L - Large Print ☐ A - Audio CD ☐ Choose not to disclose

Ethnicity: Are you of Hispanic, Latino/a, or Spanish origin? ☐ No, not of Hispanic, Latino/a, or Spanish origin ☐ Yes, Puerto Rican ☐ Yes, Dominican ☐ Yes, Mexican, Mexican American, Chicano/a ☐ Yes, Other Hispanic, Latino/a, or Spanish origin ☐ Yes, Cuban ☐ Choose not to disclose

Race: Which category best describes your race? ☐ White ☐ Black or African American ☐ Asian Indian ☐ American Indian/Alaska Native ☐ Native Hawaiian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Samoan ☐ Guamanian or Chamorro ☐ Other Pacific Islander ☐ Middle Eastern/North African ☐ Two or more races ☐ Some other race ☐ Choose not to disclose

Language: What is your preferred language? ☐ English ☐ Spanish ☐ Chinese/Cantonese ☐ Chinese/Mandarin ☐ Russian ☐ French Creole (Haitian Creole) ☐ Bengali ☐ Yiddish ☐ French ☐ Italian ☐ Korean ☐ Arabic ☐ Polish ☐ Tagalog ☐ Greek ☐ Albanian ☐ Urdu ☐ Vietnamese ☐ Portuguese ☐ Hindi ☐ American Sign Language ☐ Other language ☐ Choose not to disclose

Spouse

Pronouns: What are your pronouns? ☐ He/him ☐ She/her ☐ They/them ☐ Choose not to disclose

Sexual Orientation: Which of the following best describes you? ☐ Straight or heterosexual ☐ Lesbian or gay ☐ Bisexual ☐ Queer, pansexual, and/or questioning ☐ Don't Know ☐ Other option not specified (something else) ☐ Choose not to disclose

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Dependent 1

Pronouns: What are your pronouns? ☐ He/him ☐ She/her ☐ They/them ☐ Choose not to disclose

Sexual Orientation: Which of the following best describes you? ☐ Straight or heterosexual ☐ Lesbian or gay ☐ Bisexual ☐ Queer, pansexual, and/or questioning ☐ Don't Know ☐ Other option not specified (something else) ☐ Choose not to disclose

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Dependent 2

Pronouns: What are your pronouns? ☐ He/him ☐ She/her ☐ They/them ☐ Choose not to disclose

Sexual Orientation: Which of the following best describes you? ☐ Straight or heterosexual ☐ Lesbian or gay ☐ Bisexual ☐ Queer, pansexual, and/or questioning ☐ Don't Know ☐ Other option not specified (something else) ☐ Choose not to disclose

Accessible Format: ☐ Not applicable ☐ B - Braille ☐ L - Large Print ☐ A - Audio CD ☐ Choose not to disclose

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continued

Dependent 3

Pronouns: What are your pronouns? ☐ He/him ☐ She/her ☐ They/them ☐ Choose not to disclose

Sexual Orientation: Which of the following best describes you? ☐ Straight or heterosexual ☐ Lesbian or gay ☐ Bisexual ☐ Queer, pansexual, and/or questioning ☐ Don't Know ☐ Other option not specified (something else) ☐ Choose not to disclose

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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 Company 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 when 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 ______________

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-affiliate, 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 understand 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.

ConnectiCare is the brand name used for products and services provided by one or more ConnectiCare group of subsidiary companies. In Connecticut, individual and family health coverage is underwritten by ConnectiCare, Inc. (CCI), a licensed health care center, or by ConnectiCare Benefits, Inc. (CBI) or ConnectiCare Insurance Company, Inc. (CICI), licensed insurers. Individual, family and group dental coverage is underwritten by CICI. Group health coverage is insured by CCI or insured or administered by CICI. In Massachusetts, group health insurance is underwritten by ConnectiCare of Massachusetts, Inc. (CMI), a licensed HMO. All insurance contracts, policies, and group benefit plans contain exclusions and limitations. Not all coverage is available in all markets. For costs and details of coverage, call or write your insurance broker or the company.

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