SOLO Individual Application/Change Form

Thank you for your interest in ConnectiCare Individual Health Insurance. Now that you have found the right plan for you, here's how to apply for coverage:

- **Online:** Go to **connecticare.com/solo** and complete an online application, and click "Submit" for processing.
- **With a broker:** Ask your broker to send you an email invitation with details about your plan options and a link to the online application.
- **Paper form:** If you can't apply online, you can use this paper form; please allow up to 14 days to process. Applications should be mailed to:

  ConnectiCare, Inc. and Affiliates,
  ATTN: SOLO Intake, 175 Scott Swamp Road,
  Farmington, CT 06034 or fax **860-678-5274**

Open Enrollment:

For 2025, the annual open enrollment period will be Nov. 1, 2024 through Dec. 15, 2024 for coverage effective Jan. 1, 2025.

Special Enrollment Period:

Individuals can experience a qualifying event that makes them eligible to apply for health care coverage outside of the annual open enrollment period. If you have experienced a qualifying event, you can apply for coverage within 60 days following the event, except in the case of pregnancy and enrollment of a newborn.

If you apply for a Special Enrollment period based on pregnancy, you must apply within 30 days of the commencement of the pregnancy, as certified by a licensed health care professional acting within the scope of their practice.

If you apply for a Special Enrollment period for a newborn child, you must apply within 91 days of the child's date of birth.

Broker Commission Disclosure:

Premium for all individual policies includes the cost of using a licensed insurance broker to assist individuals in selecting a plan. Insurance brokers are paid a monthly per member per month fee of $18 up to a maximum of $54 per application.

continued

ConnectiCare

SOLO Individual Application/Change Form

P.O. Box 4058, Farmington, CT 06034-4058 ■ www.connecticare.com ■ 800-723-2986 (Sales Dept.)

APPLICANT INFORMATION:

☐ New Application ☐ Qualifying Event ☐ Renewal: Policy Number ____________________
☐ Renewal Plan Change ☐ Add Dependent ☐ Remove Dependent ☐ Other ______________________________

Effective Date (mm/dd/yyyy)

Marital Status: ☐ Single ☐ Married (Civil Union) ☐ Legally Separated ☐ Domestic Partnership (Affidavit Required)

Email Address

Primary Telephone Number: ☐ Home ☐ Cell ☐ Work

Secondary Telephone Number: ☐ Home ☐ Cell ☐ Work

Residential Street Address (P.O. Box alone not accepted)

City | State | ZIP Code

Mailing Address (if different from Residential Address – P.O. Box is accepted)

City | State | ZIP Code

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
Applicant/Subscriber (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		

***Domestic Partner:** Affidavit of Domestic Partnership Form must be completed and submitted with the application

Other insurance information (REQUIRED FIELDS)

Will this policy replace any other health insurance policy currently active? ☐ Yes ☐ No
If yes, name of other insurance carrier: ____________________ If ConnectiCare, provide policy number: _______________

Type of coverage: ☐ Employer ☐ Individual

Are you or any of your dependents enrolled in Medicare or any Medicare Advantage program? ☐ Yes ☐ No
If yes, name of person(s) and coverage type:____

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

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

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

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

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

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

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

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

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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

RESPONSIBLE PARTY:

First Name	Last Name	Email	Telephone Number ☐ Home ☐ Cell ☐ Work	
Street Address		City	State	ZIP

BROKER SECTION:

National Producer Number (NPN)	Email:
Broker Name (Print)	Broker Signature ▶

2025 PLANS (Please select one. Pharmacy is included in all SOLO plan options.)

POS Benefit Plans – In-Network Deductible:	HMO Benefit Plans – In-Network Deductible:
☐ Choice SOLO POS Coins. $4,000 ded. ☐ Choice SOLO POS Copay/Coins. $5,500 30% ded. ☐ Choice SOLO POS Copay/Coins. $6,000 ded.	☐ Choice SOLO HMO Copay/Coins. $7,700 ded.

HSA Compatible Plans - In-Network Deductible:

☐ Choice SOLO POS HSA Coins. $3,500 ded. ☐ Choice SOLO POS HSA Coins. $6,000 ded. ☐ Choice SOLO HMO HSA $6,500 ded.	**Health Savings Account (HSA)** An HSA is a tax-free fund that can be used to pay for qualified medical and/or pharmacy expenses. ConnectiCare has partnered with Health Equity to provide this service to our customers. Benefits include a full integration of enrollment and claim payments. **Please confirm if you would like to open an account with Health Equity:** ☐ Yes ☐ No

Adult Dental: ☐ $25 Deductible, 100%/100%/0%, unlimited max., no ortho.
Note: Pediatric dental coverage for children age 26 or younger is included under the medical plan.

STATEMENT OF ACCOUNTABILITY

To be completed when the applicant cannot complete the application.

I, ______________________________, personally read and completed this application for the applicant named below because:

☐ Applicant does not read English ☐ Applicant does not speak English ☐ Applicant does not write English

☐ Other (explain): ____

I am qualified to translate the contents of this form and translated this information to: ______________________________

To the best of my knowledge I obtained and listed all information disclosed by this applicant. I also translated and fullyexplained the statements above.

____

Signature of Translator (required) Today's Date

continued

TERMS, CONDITIONS, AND CONSENT

Important: The applicant, spouse/partner, and all dependents aged 18 and over must sign this form. I (we) agree signing here I acknowledge and agree that I am a resident of the state of Connecticut and I have read and understand the information on all pages of this application. I also agree that the Member Consent below is valid as long as I am enrolled in a ConnectiCare health plan. I certify that I have personally completed this application on behalf of myself and on behalf of my dependents listed on the application who are under the age of 18. I represent that the answers and statements made herein are true, complete, and correctly recorded to the best of my knowledge and belief. I acknowledge that I have received a copy of the Outline of Coverage for the plan I selected above. I acknowledge and agree that with respect to any dependents under age 18 that I am authorized to make these statements on their behalf. I further understand and agree that: (1) this application does not give me immediate coverage; (2) the broker is only authorized to submit this application; (3) if I have knowingly provided incorrect or incomplete information on this application that ConnectiCare may rescind any policy within two years of issuance. This means that ConnectiCare will cancel coverage as if the policy never existed; and (4) I have personally read and completed this application and that application will become part of the contract between ConnectiCare and me and I agree to abide by the terms of that contract. I understand that the phone number(s) 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. **THIS PLAN IS ISSUED ON AN INDIVIDUAL BASIS AND IS REGULATED AS AN INDIVIDUAL HEALTH INSURANCE PLAN.**

► ______________________________
Applicant Signature Date

____
Print Name of Parent/Guardian (if applicable)

► ______________________________
Spouse/Partner Signature (if applicable) Date

► ______________________________
Dependent Signature (age 18 years or over) Date

► ______________________________
Dependent Signature (age 18 years or over) Date

► ______________________________
Dependent Signature (age 18 years or over) Date

IMPORTANT: MEMBER CONSENT

On my behalf and on behalf of my spouse and/or dependent(s), I hereby authorize any physician, hospital, provider, insurer, ConnectiCare Inc. (CCI), or a CCI 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 use, 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, conducting investigations, meeting CCI's contractual obligations, and performing other operations to administer my benefit plan. I understand that CCI'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 CCI 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 and that CCI 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 have the right to revoke this authorization of release of medical records at any time by giving written notice to CCI as long as CCI or others have not taken action relying on this authorization. I understand that, if I exercise such right, CCI may not be able to settle a claim, and CCI can terminate my insurance policy because my revocation of authorization prevents CCI from paying claims, conducting an investigation, meeting CCI's contractual obligations and/or performing other operations, to administer my benefit plan. I acknowledge that I have retained a copy of this authorization.

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.

continued

Disclosure of Medical Loss Ratio

The medical loss ratio is defined as the ratio of incurred claims to earned premium for the prior calendar year for managed care plans issued in Connecticut. Claims shall be limited to medical expenses for services and supplies provided to enrollees and shall not include expenses for stop loss, reinsurance, enrollee educational programs, or other cost containment programs or features.

The federal medical loss ratio has the same meaning as provided in and calculated in accordance with PPACA, PL 111-148, as amended from time to time, and regulations adopted thereunder.

- State Medical Loss Ratio for calendar year 2023 for ConnectiCare, Inc. (CCI): <83.0%>.
- Federal Medical Loss Ratio for calendar year 2023 for ConnectiCare, Inc. (CCI):
  Individual <84.7%>
  Small-Group N/A
  Large-Group 89.6%
- State Medical Loss Ratio for calendar year 2023 for ConnectiCare Insurance Company, Inc. (CICI): <90.7%>.
- Federal Medical Loss Ratio for calendar year 2023 for ConnectiCare Insurance Company, Inc. (CICI):
  Individual <91.7%>
  Small-Group <91.6%>
  Large-Group <91.9%>

FOR BUSINESS USE ONLY:	
Date Received:	Date Processed/Initials:
Date Audited/Initials:	Account Number:

ConnectiCare

Qualifying Event Attestation

An individual can experience a **qualifying event** that makes them eligible to apply for health care coverage outside the Open Enrollment Period. This is called a **Special Enrollment Period**. This form attests to my eligibility for Special Enrollment Period. By signing below, I hereby attest to the following:

To the best of my knowledge, I am eligible to apply because I have experienced the qualifying event selected below on

__________/_________/___________:
Month Day Year

- ☐ **Lost my coverage**
  An individual and/or any dependents lose Minimum Essential Coverage (MEC) not resulting from failure to pay premium or providing false information on a previous application
- ☐ **I lost my employer group coverage**
  - ☐ Termination of employment
  - ☐ Death of a covered employee
  - ☐ Covered employee's eligibility for Medicare
  - ☐ Reduction in the number of work hours
  - ☐ Employer no longer offers health coverage
- ☐ **Gained or became a dependent**
  - ☐ Through marriage
  - ☐ Birth, adoption, or placement for adoption or foster care
- ☐ **Other reasons**
  - ☐ An individual and/or dependents become eligible for an Individual Coverage Health Reimbursement Arrangement (ICHRA)
  - ☐ Child support order or other court order
  - ☐ Divorce or legal separation
  - ☐ End of dependent status (dependent turned 26)
  - ☐ An individual gets medical confirmation of a pregnancy by a licensed health care professional, in writing, within the first 30 days of the commencement of the pregnancy
  - ☐ Change in eligibility for advanced premium tax credits or cost-sharing reductions
  - ☐ Moved into the ConnectiCare service area
  - ☐ Error in enrollment
  - ☐ Plan or other carrier violated a provision of the contract for my plan
  - ☐ Released from incarceration (jail or prison)

- I understand that I am required to provide proof of my qualifying event and coverage will not begin until ConnectiCare receives and validates this proof.
- I understand and agree that if I have knowingly provided incorrect or incomplete information, ConnectiCare may rescind my policy within two years of issuance, which means that ConnectiCare will cancel coverage as if the policy never existed.
- I acknowledge that any person/company that suffers any loss due to any false statement contained in this attestation may bring a civil action against me to recover his/her losses, including attorney fees.
- I understand that any act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact found in this attestation/application is a crime punishable by penalties, imprisonment and/or restitution depending on applicable laws, and may result in the denial of benefits, rescission, or cancellation of my coverage

____
Print Name

____
Signature Date

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English ATTENTION: If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call **800-251-7722** (TTY: **711**) or speak to your provider.

Español (Spanish) ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al **800-251-7722** (TTY: **711**) o hable con su proveedor.

Português do Brasil (Portuguese) ATENÇÃO: Se você fala português, serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para **800-251-7722** (TTY: **711**) ou fale com seu provedor.

POLSKI (Polish) UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer **800-251-7722** (TTY: **711**) lub porozmawiaj ze swoim dostawcą.

中文 (Simplified Chinese) 注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 **800-251-7722**（文本电话：**711**）或咨询您的服务提供商。

Italiano (Italian) ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l' **800-251-7722** (tty: **711**) o parla con il tuo fornitore.

Français (French) ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le **800-251-7722** (TTY: **711**) ou parlez à votre fournisseur.

Kreyòl Ayisyen (Haitian Creole) ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd aladispozisyon w gratis pou lang ou pale a. Èd ak sèvis siplemantè apwopriye pou bay enfòmasyon nan fòma aksesib yo disponib gratis tou. Rele nan **800-251-7722** (TTY: **711**) oswa pale avèk founisè w la.

РУССКИЙ (Russian) ВНИМАНИЕ: Если вы говорите на русском, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются

бесплатно. Позвоните по телефону **800-251-7722** (TTY: **711**) или обратитесь к своему поставщику услуг.

Việt (Vietnamese) LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số **800-251-7722** (Người khuyết tật: **711**) hoặc trao đổi với người cung cấp dịch vụ của bạn.

العربية (Arabic)

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم **800-251-7722** (**711**) أو تحدث إلى مقدم الخدمة.

한국어 (Korean)주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. **800-251-7722** (TTY: **711**) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

SHQIP (Albanian) VINI RE: Nëse flisni shqip, shërbime falas të ndihmës së gjuhës janë në dispozicion për ju. Ndihma të përshtatshme dhe shërbime shtesë për të siguruar informacion në formate të përdorshme janë gjithashtu në dispozicion falas. Telefononi **800-251-7722** (TTY: **711**) ose bisedoni me ofruesin tuaj të shërbimit.

हिंदी **(Hindi)** ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। **800-251-7722** (TTY: **711**) पर कॉल करें या अपने प्रदाता से बात करें।

Tagalog (Tagalog) PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa **800-251-7722** (TTY: **711**) o makipag-usap sa iyong provider.

Ελληνικά (Greek) ΠΡΟΣΟΧΗ: Εάν μιλάτε ελληνικά, υπάρχουν διαθέσιμες δωρεάν υπηρεσίες υποστήριξης στη συγκεκριμένη γλώσσα. Διατίθενται δωρεάν κατάλληλα βοηθήματα και υπηρεσίες για παροχή πληροφοριών σε προσβάσιμες μορφές. Καλέστε το **800-251-7722** (TTY: **711**) ή απευθυνθείτε στον πάροχό σας.

NOTICE OF NONDISCRIMINATION POLICY

Discrimination is Against the Law

ConnectiCare complies with Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes. ConnectiCare does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

ConnectiCare:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters.
  - Written information in other formats (large print, audio, accessible electronic formats, and other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters.
  - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services contact the Civil Rights Coordinator by calling Member Services at **800-251-7722** (TTY: **711**).

If you believe that ConnectiCare has failed to provide these services or discriminated in another way based on race, color, national origin, age, disability, or sex, you can file a grievance with the Civil Rights Coordinator by writing to ConnectiCare Grievance and Appeals Department, P.O. Box 4061, Farmington, CT 06034-4061; faxing them at **800-319-0089**; or calling Member Services at **800-251-7722**. (Dial **711** for TTY services.) You can file a grievance in person, by mail, by fax, or through your secure member portal. If you need help filing a grievance, ConnectiCare's Grievance and Appeals Department is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **ocrportal.hhs.gov/ocr/portal/lobby.jsf** or by mail or phone at: **U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201**; **800-368-1019** (TTY: **800-537-7697**).

Complaint forms are available at **hhs.gov/ocr/office/file/index.html**.

This notice is available on ConnectiCare's website at **connecticare.com/legal/nondiscrimination**.