

Enrollment/Change Form

Please print clearly, complete in full using ballpoint pen.

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

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

Plan type: HMO High Deductible Health Plan (HDHP) Point-of-Service (POS) PPO FlexPOS Other
Plan Name: (from Benefit Summary) _____

ConnectiCare, Inc. = HMO, HDHP, POS Benefit Plans and ConnectiCare Insurance Company, Inc. = PPO and FlexPOS Benefit Plans
MA employers cannot purchase CCI or CICI products.

Employee's Social Security Number _____ Marital Status: Single Married/Civil Union Legally Separated Separated
 Widowed Divorced

First Name _____ Middle Name _____ Last Name _____

Street Address _____ City _____ State _____ ZIP Code _____

Home Telephone Number _____ Work Telephone Number _____ E-mail Address (optional) _____ Primary Language (optional) _____

MEMBER(S):

First Name/Middle Initial/Last Name	Add	Delete	Member Identification Number (existing members only)	Sex	Date of Birth (mm/dd/yy)	Full-Time Student	Primary Care Physician	ConnectiCare Provider ID Number	Existing Patient
Employee			_____	<input type="checkbox"/> M <input type="checkbox"/> F	/ /				<input type="checkbox"/> Yes <input type="checkbox"/> No
Spouse			_____	<input type="checkbox"/> M <input type="checkbox"/> F	/ /				<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent 1			_____	<input type="checkbox"/> M <input type="checkbox"/> F	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent 2			_____	<input type="checkbox"/> M <input type="checkbox"/> F	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent 3			_____	<input type="checkbox"/> M <input type="checkbox"/> F	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent 4			_____	<input type="checkbox"/> M <input type="checkbox"/> F	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No

Check if enrolling a disabled dependent age 19 or over and contact ConnectiCare to obtain a form for submitting proof of disability.

Other health care coverage:

Do you, your spouse or your dependent(s) have other health insurance under a group plan, HMO or Medicare? Yes No

If yes, name of person covered _____ Social Security Number _____ Employer _____

Insurance Co. Name and Address _____ Policy Number _____ Medicare (Please attach a copy of your Medicare card.)
(Please attach a copy of your group medical insurance card.) Part A Part B Retired

EMPLOYER: Complete this section. Form cannot be processed without this information.

COBRA <input type="checkbox"/> Yes <input type="checkbox"/> No	Length of coverage: <input type="checkbox"/> 18 months <input type="checkbox"/> 36 months <input type="checkbox"/> Other _____	Date of Hire (mm/dd/yy) / /	Coverage Effective Date (mm/dd/yy) / /	Coverage End Date (mm/dd/yy) / /
Group Number/Division	Group Name	Employee Work Location	Plan Name	
Employer Signature ▶	Title	Date		

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. I certify that the information supplied in the form is correct. I agree to the consent on the reverse side of this form.

▶ _____
Employee's Signature _____ Date _____