ConnectiCare®, Inc.
P.O. Box 4058, Farmington, CT 06034-4058
www.connecticare.com ■ 1-800-251-7722

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 Open Access ☐ HMO Personal Care Plan ☐ Point-of-Service Open Access Plan ☐ Point-of-Service Personal Care Plan

Employee's Social Security Number	Marital Status: ☐ Single ☐ Married ☐ Legally Separated ☐ Separated ☐ Widowed ☐ Divorced

First Name	Middle Initial	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	Social Security Number	Sex	Date of Birth (mm/dd/yy)	Primary Care Physician	Provider ID Number (8 digits)	Existing Patient	Name of OB/GYN (if female)
Employee			_ _ _ _ _ _ _ _ _	☐ M ☐ F	/ /		_ _ _ _ _ _ _ _	☐ Yes ☐ No	
Spouse			_ _ _ _ _ _ _ _ _	☐ M ☐ F	/ /		_ _ _ _ _ _ _ _	☐ Yes ☐ No	
Dependent 1			_ _ _ _ _ _ _ _ _	☐ M ☐ F	/ /		_ _ _ _ _ _ _ _	☐ Yes ☐ No	
Dependent 2			_ _ _ _ _ _ _ _ _	☐ M ☐ F	/ /		_ _ _ _ _ _ _ _	☐ Yes ☐ No	
Dependent 3			_ _ _ _ _ _ _ _ _	☐ M ☐ F	/ /		_ _ _ _ _ _ _ _	☐ Yes ☐ No	
Dependent 4			_ _ _ _ _ _ _ _ _	☐ M ☐ F	/ /		_ _ _ _ _ _ _ _	☐ Yes ☐ No	

☐ Check if enrolling a disabled dependent age 19 or over and attach 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.) ☐ Part A ☐ Part B ☐ Retired

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

COBRA ☐ Yes ☐ No If yes, bill: ☐ Member ☐ Group ☐ Third Party____________
Length of coverage: ☐ 18 months ☐ 36 months ☐ Other____________

Date of Hire (mm/dd/yy)	Date of Change (mm/dd/yy)
/ /	/ /

Group Number/Division	Group Name	Location	Plan Description

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 and you agree to keep it confidential. This authorization is valid as long as you are enrolled in a ConnectiCare health plan. 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

FAMILY HEALTH STATEMENT

CHECK ONE: New Group ❒ New Employee Add ❒ Existing Employee Change ❒

PRINT IN INK----COMPLETE BOTH SIDES OF FORM

TO BE COMPLETED BY EMPLOYER

NAME OF EMPLOYER:	EMPLOYER ADDRESS: Street :
POLICY NUMBER	City:
	ST/Zip:

APPLICANT'S OCCUPATION	HOURS WORKED/WEEK	DATE OF FULL TIME HIRE

TO DECLINE COVERAGE -- EMPLOYEE IS TO COMPLETE THIS AREA

( ) **I DECLINE** TO ENROLL FOR HEALTH COVERAGE DUE TO THE EXISTENCE FO OTHER GROUP HEALTH COVERAGE FOR: MYSELF ( ) SPOUSE ( ) DEPENDENT CHILDREN ( )

IF I and/or my dependents decline coverage and desire to participate in the plan at a later date, **I may** have to submit evidence of insurability satisfactory to the insurance company.

SIGNATURE OF EMPLOYEE: **DATE:**

TO REQUEST COVERAGE -- ANSWER ALL QUESTIONS

IF ADDITIONAL SPACE IS NEEDED, ATTACH SEPARATE SHEET -- COMPLETE FOR ALL FAMILY MEMBERS APPLYING FOR COVERAGE

FIRST NAME INITIAL LAST NAME	HEIGHT	WEIGHT	DATE OF BIRTH MM/DD/YYYY	SEX M/F	FULL TIME STUDENT Yes/No--If Yes, Name School
EMPLOYEE:					
SPOUSE:					
EMPLOYEE SOCIAL SECURITY NUMBER:					

EMPLOYEE ADDRESS: Street:	MARITAL STATUS: ( ) SINGLE ( ) MARRIED
City:	PHONE: WORK ( ) - HOME ( ) -
ST/Zip:	**WHERE WOULD YOU PREFER TO BE CALLED DURING THE DAY?** **( ) HOME ( ) WORK**

I hereby represent and agree that all the answers and statements in this request are full, complete and true, to the best of my knowledge and belief and understand that the said answers and statements form the basis upon which insurance will be made effective. I understand that omissions, misrepresentations, or misstatements about medical history could result in the denial of an otherwise valid claim and rescission, voiding, or reformation of insurance.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION IN CONNECTION WITH ELIGIBILITY FOR GROUP INSURANCE TO: All providers of medical or dental services or supplies and their representatives, the Medical Information Bureau, Inc., or other organizations, all insurers, medical or hospital service plans, prepaid health plans, employers, group policyholders or contract holders*

For purposes of determining eligibility for insurance, and eligibility for benefits under the existing policy, I authorize you to furnish any information available about the medical history, condition and treatment of the Employee, or any Dependents listed in this Health Statement, including but not limited to information related to psychiatric, alcohol and drug abuse, and HIV conditions.

I authorize the use of such information and the redisclosure of this information for the above purposes to its representatives, other organizations, and their representatives, any insurer, medical or hospital service plan, prepaid health plan or reinsurer. I also authorize the user to redisclose such information to any attending physician for treatment purposes and when necessary to inform the employee of the reason insurance was declined, to governmental authorities when necessary to prevent or prosecute fraud or other illegal activities, and to any person who has an authorization specifically permitting the redisclosure and as may be permitted or required by law.

In order to assist my employer in selecting a health insurance plan, I acknowledge that this information may be presented to more than one insurer.

I agree that this authorization is valid for 30 months from the date below and a copy shall be as valid as the original. I know that I have the right to ask for and receive a copy of this authorization.

DATE:____________________Employee Signature:_________________________Spouse Signature:____________________________

OTHER SIDE MUST BE COMPLETED IN FULL

*Under section 38a-567(2) of the Connecticut General Statute, plans and arrangements covering small employers may not exclude eligible employees or dependents based on actual or expected health conditions, except for late enrollees who fail to submit satisfactory evidence of insurability.

EMPLOYEE NAME:_________________________ (please print)

EMPLOYER NAME:_________________________ (please print)

- ARE YOU NOW ACTIVELY AT WORK FULL TIME (30+ HRS/WEEK)? ( ) YES ( ) NO
- DOES YOUR SPOUSE HAVE MEDICAL COVERAGE ELSEWHERE? ( ) YES ( ) NO
- IS ANY PERSON TO BE INSURED CURRENTLY COVERED UNDER COBRA? ( ) YES ( ) NO
- IS ANY PERSON TO BE INSURED ENROLLED IN MEDICARE? ( ) YES ( ) NO

IF YES, WHO:_________________________ ( ) MEDICARE A ( ) MEDICARE B

TO REQUEST COVERAGE--ANSWER ALL QUESTIONS **DETAILS MAY BE SUBMITTED VIA ENVELOPE MARKED "CONFIDENTIAL"**

FOR "YES" ANSWERS, DETAILS MUST BE PROVIDED. ***IF ILLNESS IS UNLISTED, PROVIDE DETAILS IN THE ROW MARKED "OTHER"***

	Question	YES	NO
1.	Are you, your spouse, or any dependent to be insured, currently disabled or unable to perform their normal activities? WHO: WHY:		
2.	Have you, or any dependent, been hospitalized, or been advised to be hospitalized within the past 5 years for any reason? WHO: WHY:		
3.	Have you, or any dependent, had surgery, or been advised to have surgery within the past 5 years for any reason? WHO: WHY:		
4.	Are you, or any dependents to be covered, currently pregnant? WHO: EXPECTED DELIVERY DATE		
5.	Is this pregnancy the result of infertility treatment? Please explain:		
6.	Are you, or any dependents to be covered, currently taking any medication? WHO:_________________________ MEDICATION:_________________________ WHY:_________________________		
7.	Have you, or any dependent, had medical expenses in excess of $5,000.00 in the last 12 months? WHO: WHY:		

8. Have you, or any dependent ever had, or has a Medical Professional told, counseled, or treated, you or any dependent, for any of the following?

	YES	NO	Person Affected	Diagnosis & Date Diagnosed	Treatment And/or Medication	Degree of Recovery	Name, Address & Phone Number of Physician and/or Hospital
a) Chest Pain, Heart Attack, or other heart condition							
b) Condition/Disease of the circulatory system (i.e. blood vessels, phlebitis, leg ulcers)							
c) Cancer, tumor, or lymph node enlargement (indicate type of cancer and location)							
d) Acquired Immuno Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)							
e) High Blood Pressure (if yes, provide most recent reading)							
f) Diabetes or disorder of endocrine system or glands (indicate if insulin dependent)							
g) Alcohol or drug use, abuse, and/or dependency							
h) Disease of the kidney, bladder or urinary tract							
i) Crohns, Colitis, diseases of stomach, intestine, esophagus or gallbladder							
j) Disorder of the liver or pancreas							
k) Disorder of the lungs or respiratory system							
l) Organ Transplants (if yes, include type and date)							
m) Neurologic problems--disorder of the brain, seizures, epilepsy, central nervous system--stroke or paralysis							
n) Nervous, mental, depression, stress or anxiety related disorder, eating disorder							
o) Disorder of the blood (including anemia)							
p) Lupus or Arthritis (if yes, indicate type and severity of disability)							
q) Congenital anomalies or disorders							
r) OTHER (any disease/condition not listed above)							