

COBRA/State Continuation Change Form CBIA Health Connections 2



1. EMPLOYER GROUP NAME: _____

Case/Cert#: _____

Change (indicate reason)

Requested effective date: _____

Add dependent (provide date of event)

_____ Marriage

_____ Birth

_____ Adoption

_____ Loss of other coverage (attach Certificate of Creditable Coverage)

Open Enrollment

Remove Dependent(s)

(indicate who is to be removed in section 3 below)

Terminate all coverage

Terminate medical coverage only

Terminate dental coverage only

Other (please specify) _____

2. CONTINUANT INFORMATION - please print clearly and complete the entire form

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Former Employee (or continuant) Name	Home Telephone ()
Street Address	Apt #: Work Telephone ()
City, State, ZIP	

3. LIST YOURSELF AND ALL ELIGIBLE DEPENDENTS IMPACTED BY THE CHANGE UNDER YOUR COVERAGE.

	Sex	Social Security #	Primary Care Physician Name and ID Number
Self (Last Name, First Name, Middle Initial)	<input type="checkbox"/> M <input type="checkbox"/> F	- -	
Spouse	<input type="checkbox"/> M <input type="checkbox"/> F	- -	
Child*	<input type="checkbox"/> M <input type="checkbox"/> F	- -	
Child*	<input type="checkbox"/> M <input type="checkbox"/> F	- -	
Child*	<input type="checkbox"/> M <input type="checkbox"/> F	- -	

Are you or your spouse entitled to Social Security Disability? Yes No

Are any of the dependent children listed above eligible for coverage as a result of an incapacity (mental/physical disability)? Yes No

Are you or any of your dependents covered by another health plan? Yes No If yes, list carrier and plan number:

*If dependent child(ren) listed are 19 (the limiting age) and attend school on a full-time basis, **attach a completed Student Verification Form.**

4. MEDICAL

NOTE: not all groups offer medical through CBIA

MEDICAL Coverage Level: Waive medical

- Self
- Self + Spouse
- Self + Child(ren)
- Family

Health Plan (choose 1 health plan & 1 benefit)

- CIGNA Health Net
- ConnectiCare Oxford

Plan of Benefits

- PPO \$500 POS \$20 CIGNA \$1500 A
- HMO \$20 POS \$20 OA CTCare \$2500 B
- HMO \$30 POS \$30 Health Net \$2500 C
- Oxford \$2000 D

Oxford USA (outside CT) (see instructions on back)

Anthem BC&BS Medicare **Additional Anthem form required for each eligible member enrolling in Anthem**

Please retain a copy for your files

5. DENTAL – AETNA

NOTE: not all groups offer dental through CBIA

Dental Coverage Level:

- Waive dental
- Self
- Self + Spouse
- Self + Child(ren)
- Family

6. AUTHORIZATION AND ACCEPTANCE

I hereby apply for the health plan and benefit plan selected, understanding all benefits and coverage as specified in the enrollment brochure and agreeing to abide by all the rules and regulations therein specified.

I authorize any provider, insurance company, employer or organization to release any information, on me or my dependents, regarding the medical, dental, mental, confidential HIV related information, alcohol or drug abuse history, treatment or benefits payable, including disability or employment-related information, to the Plan Administrator or its authorized agent for the purpose of validating and determining benefits payable in connection with this Plan. The information provided is true and correct to the best of my knowledge.

I understand my coverage and benefits may be affected by failure to provide complete and accurate information. Important! The Continuant's signature is required before submitting this application. CBIA reserves the right to deny or delay enrollment if information or required signatures are missing from this enrollment form.

Continuant Signature

Date