

Enrollment/Change Form

1. EMPLOYER NAME: _____ Pending Paperwork Number _____

For groups with 51-100 employees

Employer Group Number: _____ Division Name: _____

Enrollment <input type="checkbox"/> <input type="checkbox"/> New Group <input type="checkbox"/> New Employee <input type="checkbox"/> Existing Employee; Newly Eligible <input type="checkbox"/> Existing Employee; SPECIAL ENROLLMENT <input type="checkbox"/> Rehired/Reinstatement of Coverage <input type="checkbox"/> Open Enrollment	Change (indicate reason) <input type="checkbox"/> <input type="checkbox"/> Add Dependent (provide Date of Event) _____ Marriage/Civil Union _____ Birth _____ Adoption _____ Loss of other coverage (attach Cert. of Creditable Coverage) <input type="checkbox"/> Remove Dependents <input type="checkbox"/> Other <input type="checkbox"/> Open enrollment	Termination of Coverage <input type="checkbox"/> <input type="checkbox"/> Cancel All Coverage <input type="checkbox"/> Voluntary <input type="checkbox"/> Involuntary Termination Date _____ Cancel <u>only</u> the following coverages: <input type="checkbox"/> Med. <input type="checkbox"/> Dental <input type="checkbox"/> STD <input type="checkbox"/> LTD <input type="checkbox"/> Life <input type="checkbox"/> Supp. Life	Continuation-of-Coverage <input type="checkbox"/> Date & Type of Qualifying Event _____ Termination of Employment/ Loss of Eligibility _____ Death of Covered Employee _____ Divorce or Legal Separation _____ Dependent Child Limiting Age _____ Loss of Dependent Coverage when Employee Became Entitled to Medicare Medicare eligibility Effective date of continuation _____
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2. Employee information — please print clearly and complete the entire form

Employee Name	E-mail	Are you: <input type="checkbox"/> Actively at work <input type="checkbox"/> COBRA <input type="checkbox"/> Retired # of hours worked per week: _____
Street Address	Apt #	Do you or any dependents have Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you or any dependents have Medicare Part A _____ Part B _____ Both _____
City, State, ZIP		
	Home Telephone ()	Work Telephone ()
	Employee date of Hire/Rehire/Retirement	Part-time to Full-time Employment Date
	Marital status	Effective Date:
	<input type="checkbox"/> Single <input type="checkbox"/> Married	

3. LIST YOURSELF AND ALL ELIGIBLE DEPENDENTS TO BE ENROLLED OR CHANGED UNDER YOUR COVERAGE. Remember, each person must select a Primary Care Physician (PCP).

Name (Last Name, First Name, Middle Initial)	Sex	Full-time Student	CT Resident	Birth date MM/DD/YY	Social Security #	Medical PCP ID#	Prev. Seen	Dental PCP ID#
Employee	<input type="checkbox"/> M <input type="checkbox"/> F	N/A	N/A				Y/N	
Spouse	<input type="checkbox"/> M <input type="checkbox"/> F	N/A	N/A				Y/N	
Child	<input type="checkbox"/> M <input type="checkbox"/> F	Y/N	Y/N				Y/N	
Child	<input type="checkbox"/> M <input type="checkbox"/> F	Y/N	Y/N				Y/N	
Child	<input type="checkbox"/> M <input type="checkbox"/> F	Y/N	Y/N				Y/N	

4. MEDICAL

Coverage Level (choose one) <input type="checkbox"/> Employee <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Family	Health Plan (choose one) <input type="checkbox"/> ConnectiCare <input type="checkbox"/> Oxford <input type="checkbox"/> Oxford USA (out of area)	Waive Medical (indicate reason) <input type="checkbox"/> Other Coverage <input type="checkbox"/> No Other Coverage
Plan (choose one) HMO <input type="checkbox"/> \$20 <input type="checkbox"/> \$30/\$45 <input type="checkbox"/> \$30/\$45-\$2,500 POS <input type="checkbox"/> \$20 <input type="checkbox"/> \$20 OA <input type="checkbox"/> \$20/\$40-\$1,500 <input type="checkbox"/> \$20/\$40-\$2,500 <input type="checkbox"/> \$30/\$45 <input type="checkbox"/> \$30/\$45-\$2,500/20% Medicare <input type="checkbox"/> Anthem (Addl. forms reqd. for each employee & dependent)	HSA <input type="checkbox"/> CTCare \$2,500 B <input type="checkbox"/> Oxford \$2,000 D <input type="checkbox"/> CTCare \$2,500 E <input type="checkbox"/> Oxford \$2,500 E <input type="checkbox"/> CTCare \$3,500 F <input type="checkbox"/> Oxford \$3,500 F	Oxford USA (out of area) <input type="checkbox"/> \$20 <input type="checkbox"/> \$30 <input type="checkbox"/> POS \$20/\$40-\$1,500 <input type="checkbox"/> POS \$30/\$45-\$3,000 <input type="checkbox"/> POS \$30/\$45-\$2,500/20% <input type="checkbox"/> POS \$30/\$45-\$2,850/30% <input type="checkbox"/> POS \$30-\$2,000/30% <input type="checkbox"/> PPO \$2,000 D (HSA) <input type="checkbox"/> PPO \$3,500 F (HSA)

5. DENTAL — Aetna Waive Dental

Coverage Level (choose one) <input type="checkbox"/> Employee <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Family	Coverage level <input type="checkbox"/> Dental DMO <input type="checkbox"/> Standard PPO <input type="checkbox"/> Enhanced PPO <input type="checkbox"/> Passive PPO 1000 <input type="checkbox"/> Existing employer plan
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6. LIFE/DISABILITY — The Hartford

Life (Required) Amount \$ _____
 Dependent Life STD LTD
 Supplemental Life (complete a separate Supp. Life Enrollment Form)
 Waive STD Waive LTD
 Current annual salary: \$ _____

7. LIFE INSURANCE BENEFICIARY INFORMATION

To the EMPLOYER: This is the only record of an employee's beneficiary designation. Please retain a copy and submit it at the time of request for death benefits. This form should also be used for any changes in beneficiary designation. Please record the appropriate date.

Beneficiary Name (Last, First, MI) _____
 Relationship of Beneficiary _____ Date _____

8. 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 deductions from my earnings of the required contributions, if any, toward the cost of the coverage.
 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 employee's and employer's signatures are required before submitting this application. CBIA Service Corp. reserves the right to deny or delay enrollment if information or required signatures are missing from this enrollment form.

Employee Signature _____ Date _____
 Employer Signature _____ Date _____

If you're declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, civil union, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided you request enrollment within 30 days after the marriage, civil union, birth, adoption or placement for adoption.



Connecticut Public Act 09-46 Insurance Company Medical Loss Ratios for 2010

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 and shall otherwise be calculated in accordance with the requirements of Connecticut state law. For calendar year 2010, medical loss ratios for insurance companies that participate in CBIA Health Connections are:

ConnectiCare, Inc.	79.5%
ConnectiCare Insurance Company Inc.	73.9%
Oxford Health Plans (CT), Inc.	84.9%
Oxford Health Insurance, Inc.	78.4%
UnitedHealthcare Insurance Company	85.0%

Enrollment Instructions

- Complete all items to avoid delays in processing.
- If you are waiving medical coverage and wish to have life insurance if applicable, please complete all sections including date of birth, Social Security number and sections indicating the amount of life insurance selected, your salary—if life is salary-based, and your beneficiary. Note: If you do not elect Life, STD or LTD at the time you are first eligible, you will be required to go through Evidence of Insurability (EOI).
- If you or one of your dependents is enrolling in our Medicare plan, you must complete this form **and** the Anthem Blue Cross & Blue Shield Enrollment Forms for each employee and dependent. All forms must be completed in full, signed and dated to avoid delays in coverage.
- Your signature and date **and** your employer's signature and date must be on the Enrollment/Change Form.
- Dependents are eligible until reaching age 26.
- For Dental enrollment (section 5), choose one coverage level and one plan. Check with your employer for available dental options.
- For Supplemental Life insurance (section 6), please complete a separate Supplemental Life Insurance Enrollment Form.
- If you reside outside Connecticut and need information on which plans are available, please refer to our website at cbia.com/ins and click on Out-of-Area Information. If you need assistance in determining which health plans or benefits are available to you, contact your agent, or contact CBIA at (860) 244-1900.

Thank you for selecting coverage through CBIA Health Connections.