CBIA HEALTH CONNECTIONS 2
THE POWER OF CHOICE

For groups with 3-50 employees

Enrollment/Change Form

1. EMPLOYER NAME: _____ **Pending Paperwork Number**_____

Employer Group Number: _____ **Division Name:** _____

Enrollment ❑
- ❑ New Group
- ❑ New Employee
- ❑ Existing Employee; Newly Eligible
- ❑ Existing Employee; SPECIAL ENROLLMENT
- ❑ Rehired/Reinstatement of Coverage
- ❑ Open Enrollment

Change (indicate reason) ❑
- ❑ Add Dependent (provide Date of Event)
  - _____ Marriage/Civil Union
  - _____ Birth
  - _____ Adoption
  - _____ Loss of other coverage (attach Cert. of Creditable Coverage)
- ❑ Remove Dependents
- ❑ Other
- ❑ Open enrollment

Termination of Coverage ❑
- ❑ Cancel All Coverage
- ❑ Voluntary ❑ Involuntary

Termination Date _____

Cancel only the following coverages:
- ❑ Med. ❑ Dental ❑ STD
- ❑ LTD ❑ Life ❑ Supp. Life

Continuation-of-Coverage ❑

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 _____

2. Employee information—please print clearly and complete the entire form

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

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 PCD ID#
Employee	❑ M ❑ F	N/A	N/A				Y/N	
Spouse	❑ M ❑ F	N/A	N/A				Y/N	
Child	❑ M ❑ F	Y/N	Y/N				Y/N	
Child	❑ M ❑ F	Y/N	Y/N				Y/N	
Child	❑ M ❑ F	Y/N	Y/N				Y/N	

4. MEDICAL

Coverage Level (choose one)
- ❑ Employee
- ❑ Employee + Child(ren)
- ❑ Employee + Spouse
- ❑ Family

Health Plan (choose one)
- ❑ ConnectiCare
- ❑ Oxford
- ❑ Oxford USA (out of area)

Waive Medical (indicate reason)
- ❑ Other Coverage
- ❑ No Other Coverage

Plan (choose one)

HMO
- ❑ $20
- ❑ $30/$45
- ❑ $30/$45–$2,500

POS
- ❑ $20
- ❑ $20 OA
- ❑ $20/$40–$1,500
- ❑ $20/$40–$2,500
- ❑ $30/$45
- ❑ $30/$45–$2,500/20%
- ❑ $30/$45–$2,850/30%
- ❑ $30/$45–$3,000
- ❑ $30/$45–$5,000
- ❑ $30–$2,000/30%

HSA
- ❑ CTCare $2,500 B
- ❑ Oxford $2,000 D
- ❑ CTCare $2,500 E
- ❑ Oxford $2,500 E
- ❑ CTCare $3,500 F
- ❑ Oxford $3,500 F

Oxford USA (out of area)
- ❑ $20 ❑ $30
- ❑ POS $20/$40–$1,500
- ❑ POS $30/$45–$3,000
- ❑ POS $30/$45–$2,500/20%
- ❑ POS $30/$45–$2,850/30%
- ❑ POS $30–$2,000/30%
- ❑ PPO $2,000 D (HSA)
- ❑ PPO $3,500 F (HSA)

Medicare
- ❑ Anthem (Addl. forms reqd. for each employee & dependent)

5. DENTAL—Aetna ❑ Waive Dental

Coverage Level (choose one)
- ❑ Employee
- ❑ Employee + Spouse
- ❑ Employee + Child(ren)
- ❑ Family

Coverage level
- ❑ Dental DMO
- ❑ Standard PPO
- ❑ Enhanced PPO
- ❑ Passive PPO 1000
- ❑ Existing employer plan

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.

Employer—Please retain a copy for your files

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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.