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 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	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)	Effective Date (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

white-ConnectiCare / white-ConnectiCare / yellow-employer / pink-member

IMPORTANT: EMPLOYEE/MEMBER CONSENT

On my behalf and on behalf of my spouse and/or dependent(s), I hereby authorized any physician, hospital, provider, insurer, ConnectiCare, Inc., (CCI) or a CCI affiliated, or other organization or person having records, data or information concerning health history or medical insurance for me or my family member(s), including but not limited to information concerning mental health, alcohol/substance abuse or HIV or AIDS-related conditions, to transfer to any person or company such records, data or information as may be required for the purpose of providing treatment, paying claims, and performing other operations to administer my Benefit Plan. I understand that CCI's privacy notice contains a more complete description of the purposes for which information about me and my dependent(s) may be used or disclosed and that I have a right to review the privacy notice prior to signing this consent. I understand that CCI may change such notice at any time but will provide me a copy of any amended notice. I understand that I have a right to request restrictions on how information about me and my dependent(s) may be used or disclosed to carry out the plan administration purposes and that CCI is not required to agree to the requested restrictions. I understand that this authorization is valid for the term of my and my dependents' coverage under the Plan. I understand that I can revoke this authorization (but will be terminated from the Plan) at any time by giving written notice to CCI as long as CCI or others have not taken action relying on this authorization. I understand that the pink copy attached is my copy of this authorization. I authorize payroll deduction, if any, for the coverage I have elected.

INSTRUCTIONS: DID YOU REMEMBER TO ...

- ☐ **Print clearly, complete all sections and sign at the bottom of page 1?**
- ☐ **Select your primary care physician and include the 8-digit Provider ID number? (Can be found in Provider Directory or on Web site)**
- ☐ **Attach a copy of your Medicare Card if you are Medicare-eligible?**