

# 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  High Deductible Health Plan (HDHP)  Point-of-Service (POS)  PPO  FlexPOS  Other  
Plan Name: (from Benefit Summary) \_\_\_\_\_

ConnectiCare, Inc. = HMO, HDHP, POS Benefit Plans and ConnectiCare Insurance Company, Inc. = PPO and FlexPOS Benefit Plans  
MA employers cannot purchase CCI or CICI products.

Employee's Social Security Number \_\_\_\_\_ Marital Status:  Single  Married/Civil Union  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	Member Identification Number (existing members only)	Sex	Date of Birth (mm/dd/yy)	Full-Time Student	Primary Care Physician	ConnectiCare Provider ID Number	Existing Patient
Employee			_____	<input type="checkbox"/> M <input type="checkbox"/> F	/ /				<input type="checkbox"/> Yes <input type="checkbox"/> No
Spouse			_____	<input type="checkbox"/> M <input type="checkbox"/> F	/ /				<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent 1			_____	<input type="checkbox"/> M <input type="checkbox"/> F	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent 2			_____	<input type="checkbox"/> M <input type="checkbox"/> F	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent 3			_____	<input type="checkbox"/> M <input type="checkbox"/> F	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent 4			_____	<input type="checkbox"/> M <input type="checkbox"/> F	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No

Check if enrolling a disabled dependent age 19 or over and contact ConnectiCare to obtain a form for submitting 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.)  
(Please attach a copy of your group medical insurance card.)  Part A  Part B  Retired

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

COBRA  Yes  No Length of coverage:  18 months  36 months  Other \_\_\_\_\_ Date of Hire (mm/dd/yy) / / Coverage Effective Date (mm/dd/yy) / / Coverage End Date (mm/dd/yy) / /

Group Number/Division \_\_\_\_\_ Group Name \_\_\_\_\_ Employee Work Location \_\_\_\_\_ Plan Name \_\_\_\_\_

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. This authorization is valid as long as you are enrolled in a ConnectiCare health plan, and for one year after enrollment in the plan ends. 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 \_\_\_\_\_

### **IMPORTANT: EMPLOYEE/MEMBER CONSENT**

On my behalf and on behalf of my spouse and/or dependent(s), I hereby authorize any physician, hospital, provider, insurer, ConnectiCare Inc., (CCI), ConnectiCare Insurance Company, Inc. (CICI) 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/CICI'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/CICI 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/CICI 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 and for one year thereafter. I understand that I can revoke this authorization (but will be terminated from the Plan) at any time by giving written notice to CCI/CICI as long as CCI/CICI 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.

I understand that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime punishable by penalties, imprisonment and restitution depending on applicable laws.

### **INSTRUCTIONS: DID YOU REMEMBER TO ...**

- Print clearly, complete all sections and sign at the bottom of page 1?**
- Clearly define (write in) the plan name you requested?**  
**(It is located at the top left of the Benefit Summary.)**
- Select your primary care physician and include the ConnectiCare Provider ID number?**  
**(Can be found in the Provider Directory or on Web site)**
- Attach a copy of your Medicare Card if you are Medicare-eligible?**
- Attach a copy of your group medical insurance card if you have other coverage?**