

1. EMPLOYER NAME: _____

Employer Group Number: _____ Division: _____

Enrollment/Change Form

For groups with 3-50 employees

Enrollment Change Termination of Coverage Continuation-of-Coverage (Attach election form)
Group of 3-50 ees
New Group
New Employee
Existing Employee Newly Eligible
Existing Employee: SPECIAL ENROLLMENT
Rehired/Reinstatement of Coverage
Open Enrollment
(A completed Family Health Statement is required for all of the above)
Change (indicate reason)
Add Dependent (provide Date of Event)
Marriage
Adoption
Loss of Other Coverage (attach Cert. of Creditable Coverage)
Remove Dependents
Other
Open enrollment
Termination of Coverage
Canceling All Coverage
Termination Date
Cancel only the following coverages:
Med. Dental STD
LTD Supplemental Life
Continuation-of-Coverage (Attach election form)
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
Effective date of continuation

2. EMPLOYEE INFORMATION - PLEASE PRINT CLEARLY AND COMPLETE THE ENTIRE FORM Rev 10/04 HC 3-50

Employee Name Home Telephone Employee date of Hire/Rehire/Retirement
Street Address Apt #: Work Telephone Part-time to Full-time Employment Date:
City, State, ZIP Marital status Effective Date:
Are you: Actively at work COBRA Retired
of hours worked per week:
Do you or any dependents have Medicare? Yes No
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/NUMBER.

Table with 7 columns: Name (Last Name, First Name, Middle Initial), Sex, Full-time Student, Birth date MM/DD/YY, Social Security #, You must fill in your PCP Number and his or her Last Name, Prev. Seen. Rows for Employee, Spouse, Child, Child, Child.

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? Yes No
*If dependent child(ren) listed are 19 (the limiting age) and attend school on a full-time basis, attach a completed Student Verification Form.
Are you or any of your dependents covered by another health plan? Yes No If yes, list carrier and plan number:

4. MEDICAL (choose 1 health plan & plan of benefit) 5. DENTAL-AETNA 6. LIFE/DISABILITY - THE HARTFORD 8. AUTHORIZATION AND ACCEPTANCE
Coverage Level: Medical (choose one) Health Plan (choose one)
Waive medical
Employee
Employee + Spouse
Employee + Child(ren)
Family
Plan of Benefits
HMO \$30/\$45
HMO \$20
HMO \$10
POS \$30/\$45
POS \$20
POS \$10
POS \$10 Open Access (OA)
POS \$20 Open Access (OA)
Oxford USA (outside CT)
Anthem BC&BS Medicare
Addl. Anthem form reqd. for each eligible member
Coverage Level: Dental
Waive dental
Employee
Empl. + Spouse
Empl. + Child(ren)
Family
Life (Required) Amount \$
AD&D Amount \$
Dependent Life STD LTD
Disability: 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:
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 reserves the right to deny or delay enrollment if information or required signatures are missing from this enrollment form.
Employee Signature Date Signed
Employer Signature Date Signed

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, 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, birth, adoption or placement for adoption.

Employer— Please retain a copy for your files

(over please)

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.



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3-50
employees

Enrollment Instructions

- Complete all items 1-8 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 6 & 7 indicating the amount of life insurance selected and your beneficiary.
- If you or one of your dependents is enrolling in our Medicare Primary plan, you must complete this form **and** the Anthem Blue Cross & Blue Shield Enrollment Form. Both 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 19 or 23 if a full-time student. A completed Student Verification form must accompany the Enrollment/Change Form as proof of full-time student status.
- If you reside outside Connecticut and need information on which plans are available, please refer to our Web site at cbia.com and click on Out-of-Area Information or contact your broker. If you live in parts of New York, Massachusetts, New Jersey or Pennsylvania, you may be eligible for Connecticut benefits offered by ConnectiCare, Health Net and Oxford. If you live beyond these service areas you may be eligible for Oxford USA. Oxford USA is available in 41 states, including Upstate New York (Metropolitan New York is covered through Oxford CT). Oxford USA is not available in: Connecticut, Idaho, Maine, Mississippi, Montana, New Jersey, Oklahoma, South Dakota and Wyoming. If you need assistance in determining which health plans or benefits are available to you, contact your broker, or contact CBIA at (860) 244-1900.

Thank you for selecting coverage through your employer's CBIA Health Connections group insurance plan.