Enrollment/Change Form

THE POWER OF CHOICE
CBIA HEALTH CONNECTIONS 2

1. EMPLOYER NAME: _____

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

Enrollment ❒ **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 _____ Birth
  - _____ 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 HC2 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 ❒ Single ❒ Married	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.

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
Employee	❒ M ❒ F	N/A		- -		Y / N
Spouse	❒ M ❒ F	N/A		- -		Y / N
Child	❒ M ❒ F	Y* / N		- -		Y / N
Child	❒ M ❒ F	Y* / N		- -		Y / N
Child	❒ M ❒ F	Y* / N		- -		Y / N

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)

MEDICAL Coverage Level: ❒ Waive medical

(choose one)
- ❒ Employee
- ❒ Employee + Spouse
- ❒ Employee +Child(ren)
- ❒ Family

Health Plan (choose one)
- ❒ CIGNA
- ❒ CTCare
- ❒ Health Net
- ❒ Oxford

Plan of Benefits (Open Access = OA)
- ❒ PPO $500
- ❒ HMO $20
- ❒ HMO $30
- ❒ POS $20
- ❒ POS $20 OA
- ❒ POS $30
- ❒ CIGNA $1500 A
- ❒ CTCare $2500 B
- ❒ Health Net $2500 C

❒ Oxford USA (outside CT) (see instructions on back)

❒ Anthem BC&BS Medicare **Addl. Anthem form reqd. for each elig. member enrolling in Anthem**

5. DENTAL – AETNA

Coverage Level: Dental
- ❒ **Waive dental**
- ❒ Employee
- ❒ Empl. + Spouse
- ❒ Empl. + Child(ren)
- ❒ Family

6. LIFE/DISABILITY – THE HARTFORD
- ❒ Life **(Required) Amount $** _____
- ❒ AD&D **Amount $** _____
- ❒ Dependent Life ❒ STD ❒ LTD
- ❒ **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 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

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.

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.

(over please)

Employer— Please retain a copy for your files

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CBIA HEALTH CONNECTIONS 2

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.
- If you or one of your dependents is enrolling in our Medicare Primary plan, you and your dependents must complete the Anthem Blue Cross & Blue Shield Enrollment Form. You and your dependents must also provide a copy of your Medicare card. You (the employee) will also need to complete a CBIA Enrollment/Change Form. 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 19, or to age 23 if a full-time student. A completed CBIA Health Connections 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 the CBIA Health Connections Program.