

1. EMPLOYER NAME: _____ Pending Paperwork Number: _____

Employer Group Number: _____ Division Name: _____

Enrollment/Change Form

For groups with 3-50 employees

Enrollment [] For groups with 3-50 employees
[] 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/Civil Union _____ 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 [] 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

Employee Name _____ Home Telephone () _____ Employee date of: Hire/Rehire/Retirement _____ Are you: [] Actively at work [] COBRA [] Retired # of hours worked per week: _____
Street Address _____ Apt #: _____ Work Telephone () _____ 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).

Table with 8 columns: Name (Last Name, First Name, Middle Initial), Sex, Full-time Student, Birth date MM/DD/YY, Social Security #, Medical PCP ID#, Prev. Seen, Dental PCD ID#

4. MEDICAL

Coverage Level (choose one)
[] Employee
[] Employee + Spouse
[] Employee + Child(ren)
[] Family
Health Plan (choose one)
[] CIGNA
[] ConnectiCare
[] Health Net
[] Oxford
[] Oxford USA (out of area)
Waive Medical (indicate reason)
[] Other Coverage
[] No Other Coverage
Plan of Benefits (choose one)
[] HMO \$30/\$45
[] HMO \$20
[] POS \$30/\$45
[] POS \$20
[] POS \$20 Open Access (OA)
[] Oxford USA \$20
[] Anthem BC&BS Medicare
Addl. Anthem forms reqd. for each employee and dependent

5. DENTAL-Aetna

Coverage Level (choose one)
[] Employee
[] Employee + Spouse
[] Employee + Child(ren)
[] Family
[] Waive Dental Plan of Benefits
[] Dental DMO
[] Standard PPO
[] Enhanced PPO
[] Passive PPO 1000
[] Existing employer plan

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: _____

6. LIFE/DISABILITY - The Hartford

[] Life (Required) Disability:
Amount \$ _____ [] Waive STD [] Waive LTD
[] Dependent Life [] STD [] LTD Current annual salary: \$ _____

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.

(over please)

Employer — Please retain a copy for your files



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 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. If dependent lives out of state, (s)he must be a full-time student. Verification may be requested by the insurance company.
- For Dental enrollment (section 5), choose one coverage level and one plan. Check with your employer for available dental options.
- If you reside outside Connecticut and need information on which plans are available, please refer to our Web site 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.