

## **COBRA/State Continuation Change Form**

Case/Cert#:

Change (indicate reason)  ☐ Add Dependent (provide date of event)  ☐ Marriage ☐ Birth ☐ Adoption ☐ Loss of other coverage ☐ (attach Certificate of Creditable Cove	·	effective date:	:		Terminate o Terminate r Terminate o	ho is to bo all coverag medical co lental cov	e remove le verage o erage on	•			
CONTINUANT INFORMATION — PLEASE PRINT C	LEARLY AND COM	PLETE THE	ENTIRE FORM								
Former Employee (or continuant) Name						Home Telephone ( )					
Street Address Apt #:						Work Telephone ( )					
City, State, ZIP				Email							
LIST YOURSELF AND ALL ELIGIBLE DEPENDENTS TO BE ENROLLED OR CHANGED IN MEDICAL AND/OR DENTAL.											
Name (Last Name, First Name, Middle Initial)		Sex	Sex Date of Birth Social Se		ırity #	Medical	Dental	Group Dental DMO PCD #		intary Vision	
Self		□ M □ F									
Spouse (includes civil unions and domestic partners)		□ M □ F									
Child		□ M □ F									
Child		□ M □ F									
Child		□ M □ F									
Are you or your spouse entitled to Social Security Disability' Are any of the dependent children listed above eligible for c Are you or any of your dependents covered by another heal	overage as a result of a										
MEDICAL								dHealthcare			
Health Plan (choose one)  ☐ Aetna ☐ Harvard Pilgrim Health Care		Medicare				☐ Vision - Yes					
☐ ConnectiCare ☐ UnitedHealthcare/Oxford		(Addl. forms reqd. for each employee & dependent)				AUTHORIZATION AND ACCEPTANCE					
□ HSA \$6,000 □ POS \$35/\$50-\$3,500/25% □ HSA \$4,000/50% □ POS \$30/\$45-\$3,000/20%		☐ Anthem Medicare Supplement				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.					
□ HSA \$2,750/10% □ POS \$30/\$45-\$4,000 □ POS \$30-\$2,500/50% □ POS \$30/\$45-\$1,500		ConnectiCare Medicare Advantage ☐ High ☐ Low				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.					
□ POS \$35/\$50–\$2,850/30% □ POS \$25/\$40–\$2,000						Important! Your signature is required before submitting this application.  CBIA Service Corp. reserves the right to deny or delay enrollment if information or required signature is missing from this enrollment form.					
Aetna (group)         * Not available to componies with fewer than 10         Aetna (group)         DMO 100%/100%/60%*         Aetna (group)         Dental DMO           PPO Max 100%/80%/50%—\$1,250         eligible employees         Standard PPO           Passive PPO 100%/80%/50%—\$1,000         Enhanced PPO           Passive PPO 100%/80%/50%—\$1,500*         Passive PPO 1000           Passive PPO 100/80%/50%—\$2,000         Existing employer plants		plan   Passive PPO 100%/80%/50%-\$1,5			00	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, domestic partner, 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, domestic partner, birth, adoption or placement for adoption.  Continuant Signature  Date					
—Please retain a conv for your files——————		' wi	th ortho							Eff. 1/16	



## Connecticut Public Act 09-46 Insurance Company Medical Loss Ratios for 2014

The medical loss ratio is defined as the ratio of incurred claims to earned premium for the prior calendar year for managed care plans issued in Connecticut and shall otherwise be calculated in accordance with the requirements of Connecticut state law. For calendar year 2014, medical loss ratios for insurance companies that participate in CBIA Health Connections are:

Aetna Life Insurance Company*	86.4%
ConnectiCare Insurance Company Inc.*	82.6%
Harvard Pilgrim Health Care	N/A
Oxford Health Plans (CT), Inc.**	85.6%
Oxford Health Insurance, Inc.**	80.4%

<sup>\* 2014</sup> State Medical Loss Ratio

## **Enrollment Instructions**

- Complete all items to avoid delays in processing.
- If you or one of your dependents is enrolling in our Medicare plan, you must complete this form and the Enrollment Forms for the carrier you are enrolling with, and provide a copy of the Medicare card for each person enrolling. 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.
- For Dental enrollment, 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 website 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 Customer Service at (860) 525-2242.
- An affidavit may be required at time of claim to verify domestic partner relationship. See cbia.com for a copy of the affidavit.

Thank you for selecting coverage through CBIA Health Connections.

<sup>\*\*</sup> Small Group 2014 Federal Medical Loss Ratio