CBIA HEALTH CONNECTIONS
THE POWER OF CHOICE

For groups with 3-50 employees

Enrollment/Change Form

1. EMPLOYER NAME: ________________ **Pending Paperwork Number** ________

Employer Group Number: ________ **Division Name:** ________

Enrollment ❑
- ❑ New Group
- ❑ New Employee
- ❑ Existing Employee; Newly Eligible
- ❑ Existing Employee; SPECIAL ENROLLMENT
- ❑ Rehired/Reinstatement of Coverage
- ❑ Open Enrollment

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 ❑
- ❑ Cancel All Coverage

Termination is:
❑ Voluntary ❑ Involuntary

Termination Date ________

Cancel only the following coverages:
❑ Med. ❑ Dental ❑ STD
❑ LTD ❑ Life ❑ Supp. Life

Termination Date ________

Continuation-of-Coverage ❑
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
- ________ Medicare eligibility

Effective date of continuation ________

2. Employee information—please print clearly and complete the entire form

Employee Name	E-mail		Are you: ❑ Actively at work # of hours worked per week: ________
Street Address Apt #	Home Telephone ( )	Work Telephone ( )	❑ COBRA ❑ Retired
	Employee date of Hire/Rehire/Retirement	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).

Name (Last Name, First Name, Middle Initial)	Sex	Birth date MM/DD/YY	Social Security #	Medical PCP ID#	Prev. Seen	Dental PCD ID#
Employee	❑ M ❑ F				Y/N	
Spouse	❑ M ❑ F				Y/N	
Child	❑ M ❑ F				Y/N	
Child	❑ M ❑ F				Y/N	
Child	❑ M ❑ F				Y/N	

4. MEDICAL

Coverage Level (choose one)
❑ Employee ❑ Employee + Child(ren)
❑ Employee + Spouse ❑ Family

Health Plan (choose one)
❑ ConnectiCare
❑ Oxford
❑ Oxford USA (out of area)

Waive Medical (indicate reason)
❑ Other Coverage
❑ No Other Coverage

Plan (choose one)

HMO
- ❑ $20
- ❑ $30/$45
- ❑ $30/$45–$2,500

POS
- ❑ $20
- ❑ $20 OA
- ❑ $20/$40–$1,500
- ❑ $20/$40–$2,500
- ❑ $30/$45
- ❑ $30/$45–$2,500/20%
- ❑ $30/$45–$2,850/30%
- ❑ $30/$45–$3,000
- ❑ $30/$45–$5,000
- ❑ $30–$2,000/30%

HSA
- ❑ CTCare $2,500 B
- ❑ Oxford $2,000 D
- ❑ CTCare $2,500 E
- ❑ Oxford $2,500 E
- ❑ CTCare $3,500 F
- ❑ Oxford $3,500 F

Oxford USA (out of area)
- ❑ $20 ❑ $30
- ❑ POS $20/$40–$1,500
- ❑ POS $30/$45–$3,000
- ❑ POS $30/$45–$2,500/20%
- ❑ POS $30/$45–$2,850/30%
- ❑ POS $30–$2,000/30%
- ❑ PPO $2,000 D (HSA)
- ❑ PPO $3,500 F (HSA)

Medicare (Addl. forms reqd. for each employee & dependent)
❑ Anthem ❑ ConnectiCare

5. DENTAL—Aetna ❑ Waive Dental

Coverage Level (choose one)
- ❑ Employee
- ❑ Employee + Spouse
- ❑ Employee + Child(ren)
- ❑ Family

Coverage level
- ❑ Dental DMO
- ❑ Standard PPO
- ❑ Enhanced PPO
- ❑ Passive PPO 1000
- ❑ Existing employer plan

6. LIFE/DISABILITY—The Hartford

❑ Life **(Required)** **Amount $**________

Current annual salary: $________

❑ Dependent Life ❑ STD ❑ LTD

❑ Supplemental Life (complete a separate Supp. Life Enrollment Form)

❑ **Waive** STD ❑ **Waive** LTD

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 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.

Employer—Please retain a copy for your files

Eff. 1/13; 10/12

Connecticut Public Act 09-46
Insurance Company Medical Loss Ratios for 2011

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 2011, medical loss ratios for insurance companies that participate in CBIA Health Connections are:

Company	Ratio
ConnectiCare, Inc.*	81.3%
ConnectiCare Insurance Company Inc.*	73.3%
Oxford Health Plans (CT), Inc.**	85.0%
Oxford Health Insurance, Inc.**	80.6%

* 2011 State Medical Loss Ratio
** Small Group 2011 Federal Medical Loss Ratio

Enrollment Instructions

- Complete all items to avoid delays in processing.
- If you are waiving medical coverage but are enrolling in other coverage, 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. Note: If you do not elect Life, STD or LTD at the time you are first eligible, you will be required to go through Evidence of Insurability (EOI).
- 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 (section 5), choose one coverage level and one plan. Check with your employer for available dental options.
- For Supplemental Life insurance (section 6), please complete a separate Supplemental Life Insurance Enrollment Form.
- 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.

Thank you for selecting coverage through CBIA Health Connections.

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