HC | CBIA HEALTH CONNECTIONS — THE POWER OF CHOICE

Enrollment/Change Form

3-50 EMPLOYEES

Employer Name: ______________________ **Pending Paperwork Number** __________

Employer Group Number: ______________ **Division Name:** ______________________

Contact your benefits administrator for eligibility and available options.

ENROLLMENT/CHANGE REASON

❑ Enroll ❑ Change ❑ Terminate ❑ Other Reason ______________________

EMPLOYEE INFORMATION

Employee Name		Date of Hire/Rehire/Retirement	Part- to Full-time Employment Date		Effective Date
Street Address	Apt #	Email		Marital status ❑ Single ❑ Married	# of hours worked per week: ________ Are you: ❑ Actively at work ❑ COBRA ❑ Retired
City, State, ZIP		Home Telephone ( )	Work Telephone ( )		Do you or any dependents have Medicare? Part A ____ Part B ____ Both ____

LIST YOURSELF AND ALL ELIGIBLE DEPENDENTS

Name (Last Name, First Name, Middle Initial)	Gender	Birth date MM/DD/YY	Social Security #	Medical	Vision	Dental	Dental DMO PCD #
Employee	❑ M ❑ F						
Spouse Includes civil unions and domestic partners	❑ M ❑ F						
Child	❑ M ❑ F						
Child	❑ M ❑ F						
Child	❑ M ❑ F						
Child	❑ M ❑ F						

MEDICAL

Waive Medical (indicate reason)

❑ Other group coverage ❑ Military coverage ❑ Medicare coverage ❑ Medicaid coverage ❑ Individual coverage through state exchange ❑ No other coverage

Health Plan (choose one)

❑ ConnectiCare ❑ Harvard Pilgrim Health Care

Plan (choose one)

❑ HSA $6,500
❑ HSA $5,000/50%
❑ HSA $2,800/20%
❑ POS $35/$50–$4,000/50%
❑ POS $35/$50–$2,500/50%
❑ POS $35/$50–$5,000/25%
❑ POS $35/$50–$3,750/25%
❑ POS $30/$50–$3,000/25%
❑ POS $25/$40–$2,000
❑ POS $30/$45–$1,500

Medicare (Additional forms are required for each employee & dependent)

❑ Anthem Medicare Supplement ConnectiCare Medicare Advantage: ❑ High ❑ Low

LIFE & DISABILITY

Group Basic Life

❑ Life (Required)
Amount $______________
If life amount is salary-based, enter your annual salary $______________

STD/LTD

❑ Elect STD ❑ Waive STD
❑ Elect LTD* ❑ Waive LTD
Annual salary $________________
* Not available to employees who work fewer than 30 hours per week

Voluntary Life
(for groups with 10 or more eligible employees)

Employee

❑ Waive
❑ Elect $______________ OR ______ x salary
If life amount is salary-based, enter your annual salary $_________
Amounts over $100,000 require a Personal Health Application.

Dependent

❑ Waive
❑ Spouse
Amount $______________ (Amounts over $50,000 require a Personal Health Application.)
❑ Child(ren)
❑ Both

Supplemental Life
(for groups with 3 to 9 eligible employees)

❑ Waive ❑ Elect

If electing Supplemental Life, complete a separate Supplemental Life Enrollment Form.

Beneficiary

This is the only record of your beneficiary designation. Please retain a copy and give a copy to your employer to submit at the time of request for death benefits.

Beneficiary Name (Last, First, MI) ______________________

Relationship of Beneficiary ______________________ Date ________

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CBIA HEALTH CONNECTIONS
THE POWER OF CHOICE

Employee Name:__________________________________

Employer Group Number:____________________

DENTAL

Voluntary - Ameritas

- ❑ Waive
- ❑ Passive PPO 100%/80%/0%–$750
- ❑ Passive PPO 100%/50%/50%–$750
- ❑ Active PPO 100%/80%/50%–$1,000
- ❑ Passive PPO 100%/80%/50%–$1,000
- ❑ Passive PPO 100%/80%/50%–$1,500 with ortho

Group - Aetna

- ❑ Waive
- ❑ DMO 100%/100%/60%*
- ❑ PPO Max 100%/80%/50%–$1,250
- ❑ Passive PPO 100%/80%/50%–$1,000
- ❑ Passive PPO 100%/80%/50%–$1,500*
- ❑ Passive PPO 100%/80%/50%–$2,000

* Not available to companies with fewer than 10 eligible employees

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

VISION

❑ Waive ❑ Elect

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. 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.

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.

Employee Signature ____________________ Date __________

Employer Signature ____________________ Date __________

Connecticut Public Act 09-46
Insurance Company Medical Loss Ratios for 2015

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 2015, medical loss ratios for insurance companies that participate in CBIA Health Connections are:

ConnectiCare Insurance Company Inc.*	88.3%
Harvard Pilgrim Health Care**	112.7%

* 2015 State Medical Loss Ratio
** Small Group 2015 Federal Medical Loss Ratio

CBIA • 350 Church St., Hartford, CT 06103-1126 • 860.244.1900

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