ConnectiCare, Inc. & Affiliates
P.O. Box 4058, Farmington, CT 06034-4058
www.connecticare.com ■ 1-800-251-7722

Enrollment/Change Form

Please print clearly, complete in full using ballpoint pen.

EMPLOYEE: Complete the following two sections, sign at bottom and read information on reverse side.

Please check appropriate item: ☐ New Enrollment ☐ Terminate Enrollment ☐ Add Dependent ☐ Remove Dependent ☐ Change Provider ☐ Change Division ☐ COBRA Election ☐ Other (Name change, address change, etc. Indicate reason for change.) _____

Plan type: ☐ HMO ☐ High Deductible Health Plan (HDHP) ☐ Point-of-Service (POS) ☐ PPO ☐ FlexPOS ☐ Other
Plan Name: (from Benefit Summary) _____

ConnectiCare, Inc. = HMO, HDHP, POS Benefit Plans and ConnectiCare Insurance Company, Inc. = PPO and FlexPOS Benefit Plans. MA employers cannot purchase CCI or CICI products.

Marital Status: ☐ Single ☐ Married/Civil Union ☐ Domestic Partner ☐ Legally Separated ☐ Separated ☐ Widowed ☐ Divorced

First Name	Middle Name	Last Name

Street Address	City	State	ZIP Code

Home Telephone Number	Work Telephone Number	E-mail Address	Primary Language (optional)

MEMBER(S): First Name/Middle Initial/Last Name	Add	Delete	Social Security Number (required)	Sex	Date of Birth (mm/dd/yy)	Primary Care Provider	ConnectiCare Provider ID Number (optional)	Existing Patient
Employee				☐ M ☐ F				☐ Yes ☐ No
Spouse/Civil Union/Domestic Partner				☐ M ☐ F				☐ Yes ☐ No
Dependent 1				☐ M ☐ F				☐ Yes ☐ No
Dependent 2				☐ M ☐ F				☐ Yes ☐ No
Dependent 3				☐ M ☐ F				☐ Yes ☐ No

Race/Ethnicity (optional):
This information is designed for the purpose of data collection and will not be used to determine eligibility, rating or claim payment.

Employee:
☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian ☐ Amer. Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Other _____ ☐ Unknown

Spouse/Civil Union/Domestic Partner:
☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian ☐ Amer. Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Other _____ ☐ Unknown

Dependent 1:
☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian ☐ Amer. Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Other _____ ☐ Unknown

Dependent 2:
☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian ☐ Amer. Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Other _____ ☐ Unknown

Dependent 3:
☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian ☐ Amer. Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Other _____ ☐ Unknown

☐ Check if enrolling a disabled dependent age 26 or over and contact ConnectiCare to obtain a form for submitting proof of disability.

Other health care coverage:
Do you, your spouse or your dependent(s) have other health insurance under a group plan, HMO or Medicare? ☐ Yes ☐ No

If yes, name of person covered	Employer

Insurance Co. Name and Address (Please attach a copy of your group medical insurance card.)	Policy Number	Medicare (Please attach a copy of your Medicare card.) ☐ Part A ☐ Part B ☐ Retired

EMPLOYER: Complete this section. Form cannot be processed without this information.

COBRA ☐ Yes ☐ No	Length of coverage: ☐ 30 months ☐ 36 months ☐ Other _____	Date of Hire (mm/dd/yy) / /	Hours per week _____	Coverage Effective Date (mm/dd/yy) / /	Coverage End Date (mm/dd/yy) / /

Employee Work Location	Group Name	Plan Name	Group Number/Division

Employer Signature ▶	Title	Date

Important: By signing here you are indicating that you have read and understand the information on the front **and back** of this form. This authorization is valid as long as you are enrolled in a ConnectiCare health plan, and for one year after enrollment in the plan ends. I certify that the information supplied in the form is correct. I agree to the consent on the reverse side of this form. ▶

Employee's Signature Date

IMPORTANT: EMPLOYEE/MEMBER CONSENT

On my behalf and on behalf of my spouse and/or dependent(s), I hereby authorize any physician, hospital, provider, insurer, ConnectiCare Inc., (CCI), ConnectiCare Insurance Company, Inc. (CICI) or a CCI affiliated, or other organization or person having records, data or information concerning health history or medical insurance for me or my family member(s), including but not limited to information concerning mental health, alcohol/substance abuse or HIV or AIDS-related conditions, to transfer to any person or company such records, data or information as may be required for the purpose of providing treatment, paying claims, and performing other operations to administer my Benefit Plan. I understand that CCI's/CICI's privacy notice contains a more complete description of the purposes for which information about me and my dependent(s) may be used or disclosed and that I have a right to review the privacy notice prior to signing this consent. I understand that CCI/CICI may change such notice at any time but will provide me a copy of any amended notice. I understand that I have a right to request restrictions on how information about me and my dependent(s) may be used or disclosed to carry out the plan administration purposes and that CCI/CICI is not required to agree to the requested restrictions. I understand that this authorization is valid for the term of my and my dependents' coverage under the Plan and for one year thereafter. I understand that I can revoke this authorization (but will be terminated from the Plan) at any time by giving written notice to CCI/CICI as long as CCI/CICI or others have not taken action relying on this authorization. I acknowledge that I have retained a copy of this authorization. I authorize payroll deduction, if any, for the coverage I have elected.

I understand that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime punishable by penalties, imprisonment and restitution depending on applicable laws.

ConnectiCare collects race/ethnicity data solely for the purposes of developing quality improvement programs, education, training, and marketing purposes. This data will not be used for determining eligibility, rating or claim payment.

INSTRUCTIONS: DID YOU REMEMBER TO ...

- ☐ **Print clearly, complete all sections and sign at the bottom of page 1?**
- ☐ **Clearly define (write in) the plan name you requested?**
  (It is located at the top left of the Benefit Summary and is included in your enrollment package.)
- ☐ **Select your primary care physician and include the ConnectiCare Provider ID number?**
  (Can be found in the Provider Directory or on Web site)
- ☐ **Attach a copy of your Medicare Card if you are Medicare-eligible?**
- ☐ **Attach a copy of your group medical insurance card if you have other coverage?**
- ☐ **Insert Social Security Number for each dependent?**
- ☐ **Retain a copy of this form for your records?**

DISCLOSURE OF MEDICAL LOSS RATIO

The Medical Loss Ratio is the ratio of incurred claims to the earned premium for the prior calendar year, for managed care plans in Connecticut and is calculated in accordance with Connecticut law.

Medical Loss Ratio for calendar year 2009 for ConnectiCare, Inc. (CCI): 88.9%

Medical Loss Ratio for calendar year 2009 for ConnectiCare Insurance Company, Inc. (CICI): 96.0%