

1. EMPLOYER NAME: _____ Pending Paperwork Number: _____

Employer Group Number: _____ Division Name: _____

Enrollment/Change Form

For groups with 3-50 employees

Enrollment Change Termination of Coverage Continuation-of-Coverage
For groups with 3-50 employees
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
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
Street Address, Apt #, Work Telephone, Part-time to Full-time Employment Date, Do you or any dependents have Medicare?
City, State, ZIP, Marital status, 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/NUMBER.

Table with 7 columns: Name (Last Name, First Name, Middle Initial), Sex, Full-time Student, Birth date MM/DD/YY, Social Security #, You must fill in your PCP Carrier ID number and their Last Name, Prev. Seen. Rows for Employee, Spouse, Child, Child, Child.

Are you or your spouse entitled to Social Security Disability? Yes No Are any of the dependent children listed above eligible for coverage as a result of an incapacity? Yes No
*If dependent child(ren) listed are 19 (the limiting age) and attend school on a full-time basis, attach a completed Student Verification Form.
Are you or any of your dependents covered by another health plan? Yes No If yes, list carrier and plan number:

4. MEDICAL (choose 1 health plan & plan of benefit) 5. DENTAL-Aetna 6. LIFE/DISABILITY - The Hartford 8. AUTHORIZATION AND ACCEPTANCE
Coverage Level: Medical (choose one) Health Plan (choose one) Waive Medical
Plan of Benefits
Coverage Level: Dental
Life (Required) Amount \$
Dependent Life, STD, LTD
Disability: Waive STD, Waive LTD
Current annual salary: \$
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:
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

(over please)



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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 Primary plan, you must complete this form **and** the Anthem Blue Cross & Blue Shield Enrollment Forms. 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 19 or 23 if a full-time student. A completed Student Verification form must accompany the Enrollment/Change Form as proof of full-time student status.
- 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 or contact your agent. Health Net offers coverage in New Jersey, select counties in Pennsylvania and select counties in New York. Oxford offers coverage in many states through the Oxford USA plan. Employees who live in certain counties in the tri-state area are eligible for POS plans. ConnectiCare is available in select counties in New York and Massachusetts. CIGNA is only available to Connecticut residents. 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 your employer's CBIA Health Connections group insurance plan.