

Return all paperwork to: **ConnectiCare Small-Group Sales, 175 Scott Swamp Road, Farmington, CT 06034-4050**

### IMPORTANT: Eligibility/Enrollment Facts

1. In order to ensure that your group receives its ID cards/member materials for the requested effective date, we require a 15<sup>th</sup> of the month submission date. If a case submission is not complete and received in a timely manner, we will require the completion of a Late Submission Form. Groups submitted after the 15<sup>th</sup> of the month are not guaranteed approval for the requested effective date.
2. Participation requires 75% of all eligible employees for groups of 2-9, 65% participating for groups of 10-50 (working 30 hours or more per week). POS, FlexPOS and PPO Plans require 70% of eligible enrollees to live in the Connecticut, Massachusetts or New York service area. Employees with proof of spousal coverage are not counted in the 75% or 65%.
3. Employer is required to read, complete and sign the Application indicating plan choice. Subsequent plan changes are available only on group renewal date.
4. Each enrolling employee must fully complete all sections of the ConnectiCare Group Enrollment/Change Form and select a PCP. (Even if selecting an open access plan.)
5. Each employee must complete, date and sign the “Family Health Statement”. All “yes” answers must be explained. (on front and back) (N/A for Massachusetts domiciled employer groups)
6. All businesses with employees must submit the applicable state’s quarterly earnings report\*:
  - Connecticut UC-5A/UC2
  - Massachusetts WR-1

* Sole Proprietorship (Not on Quarterly Earnings Report) Submit one of the following: Schedule C filed with IRS 1040 (profit or loss from business), Schedule F, filed with IRS 1040 (profit or loss from farming)	* Partnership (Not on Quarterly Earnings Report) Submit one of the following: Form 1065, also filed with IRS 1040, this should include K-1’s for each partner	* Corporation (Not on Quarterly Earnings Report) Submit one of the following: 1120 C-Corporation 1120C S-Corporation 1120S
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7. Complete New Business Certification Statement, if applicable.
8. Please submit first month’s premium payable to ConnectiCare.
9. Agent Information must be completely filled out to obtain commission, including the tax ID #'s. Agents must be licensed, and appointed with ConnectiCare.
10. Products are available based on ZIP code of employer.

### Small-Group Case Submission Checklist (1-50 lives)

- Small-Group Employer Application **with plan option choice and pharmacy option - completed and signed.**
- Copy of Sold Quote
  - New Hire Waiting Period (cannot be less than 0/greater than 180 days)
- First Month’s Premium - **Please make check payable to ConnectiCare.**
- ConnectiCare Enrollment Forms **dated and signed**
- Family Health Statements<sup>†</sup> for every eligible employee **dated and signed (not required for Massachusetts-based Employer Groups)**
  - Number of hours worked *must* be completed on Family Health Statement\*
  - All “yes” answers must include explanations on Family Health Statement\* (on front and back)
- Applicable Spousal/Medicare/Medicaid/Parental/Retiree Waivers to meet Underwriting Guidelines (Complete the Waiver Form or Family Health Statement.)
- Copy of the current carrier bill to provide proof of prior coverage
- \*Copy of employers **most recent Tax Filing State Quarterly Wage & Tax Form** (UC2/UC5A for CT, WR1 for MA; Schedule C for a one-life group)
- Everyone on tax documentation must be accounted for (i.e. - # of waivers + # of enrollment forms = total eligibles).
- Groups purchasing ConnectiCare of Massachusetts coverage must include a copy of the Massachusetts non-discrimination certification form.

<sup>†</sup> Family Health Statements are **not** required for Massachusetts employers.  
 Waiver forms explain which waivers do and do not affect participation.



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### Company Information

1. Legal Business Name \_\_\_\_\_ Small Group # \_\_\_\_\_  
ConnectiCare use only
2. Physical Address \_\_\_\_\_ P.O. Box \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_  
E-mail \_\_\_\_\_ SIC Code \_\_\_\_\_
3. Nature of Business \_\_\_\_\_ Billing/Contact Person \_\_\_\_\_
4. Number of Full-Time eligible Employees (working 30 or more hours per week) \_\_\_\_\_ | \_\_\_\_\_ % Participation  
Number enrolled \_\_\_\_\_ Number of spousal/applicable waivers \_\_\_\_\_ Number of "other" waivers \_\_\_\_\_
5. Desired Effective Date \_\_\_\_\_ Sold Quote # \_\_\_\_\_  
New Hire Waiting Period  0  30  60  90  180 Days  First of month following new hire waiting period selected  
Is this a Replacement Group Case?  Yes  No Prior Carrier Name \_\_\_\_\_  
 ConnectiCare is the sole carrier for medical coverage.
6. Organization Type:  Corporation  Partnership  Sole Proprietorship  Other \_\_\_\_\_
7. Other company affiliates, subsidiaries: \_\_\_\_\_
8. Federal Tax Identification Number \_\_\_\_\_ Business Effective Date \_\_\_\_\_ Current Ownership Date \_\_\_\_\_
9. Premium \$ \_\_\_\_\_ Check # \_\_\_\_\_  Composite Rated (Group 25-50 in Connecticut, all Massachusetts groups)  
 List Rated (Connecticut groups only) Other Options:  Dual Option (2-50)  Triple Option (3-50)
10. Small Employer Certification: Pursuant to Connecticut Public Act 90-134 ("PA90-134"), as amended, and Massachusetts provision of chapter 176J of the Massachusetts Insurance laws, carriers doing business in the small employer market in the states of Connecticut and Massachusetts are responsible for determining if an employer group meets the eligibility criteria for small employers. The guaranteed issue and renewability provision and ConnectiCare's underwriting guidelines are contingent upon this criteria being met. Certification of eligibility is required herein and prior to renewal. Company hereby certifies that it is a small group under applicable state law. Your Group Health Plan will become effective upon approval of ConnectiCare. I certify that the information herein is true and complete to the best of my knowledge. I also certify that all eligible employees are covered by Workers' Compensation insurance except when exempt under applicable law and all employees have equal access to ConnectiCare. I agree to immediately notify ConnectiCare of any changes to the information provided herein. On behalf of the employer, I also agree to the terms and conditions of the Group Membership Agreements, including any riders and addendums, that govern the plans issued by ConnectiCare to the employer. I understand that false and/or incomplete responses or statements may result in cancellation or rescission of coverage. ConnectiCare reserves the right to request any reasonable documentation from company, firms, subscribers or dependents in order to verify eligibility.
- Employer Signature **X** \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

### Agent Information

11. Agency Name \_\_\_\_\_ Agent Name \_\_\_\_\_
12. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_ Commission Paid to:  Agency  Agent  
Social Security # or Tax ID-06# \_\_\_\_\_ ConnectiCare Appointment  Yes  No  
Must be completed to ensure proper commission payment.
13. I have reviewed the answers on all applications and forms and I am not aware of any additional information that would affect the underwriting of this case. I agree to immediately notify ConnectiCare of any changes to the information provided herein or become aware of any information that could affect the underwriting of this case. I certify that each employee has completed and signed all forms, and selected a PCP.
- Agent Signature **X** \_\_\_\_\_ Date \_\_\_\_\_

(See Part 2 for plan selection.)

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### CONNECTICARE, INC. (CCI): CT DOMICILED ONLY

#### Hospital Copayment Plans – Calendar Year

HMO	POS
1. <input type="checkbox"/> HMO-0A-10-20-AHOA	7. <input type="checkbox"/> POS-0A-10-20-AHNA
2. <input type="checkbox"/> HMO-0A-15-25-AHOA	8. <input type="checkbox"/> POS-0A-15-25-AHNA
3. <input type="checkbox"/> HMO-0A-20-30-AACA	9. <input type="checkbox"/> POS-0A-20-30-AAXA
4. <input type="checkbox"/> HMO-0A-20-30-AADA	10. <input type="checkbox"/> POS-0A-20-30-AHPA
5. <input type="checkbox"/> HMO-0A-30-45-AAHA	11. <input type="checkbox"/> POS-0A-30-45-AAHA
6. <input type="checkbox"/> HMO-0A-30-45-AADA	

#### Hospital Deductible Plans – Calendar Year

HMO	POS
12. <input type="checkbox"/> HMO-0A-15-25-DHQA	17. <input type="checkbox"/> POS-0A-15-25-DAUA
13. <input type="checkbox"/> HMO-0A-20-30-DHRA	18. <input type="checkbox"/> POS-0A-20-30-DAWA
14. <input type="checkbox"/> HMO-0A-30-45-DHQA	19. <input type="checkbox"/> POS-0A-30-45-DAUA
15. <input type="checkbox"/> HMO-0A-30-45-DHRA	20. <input type="checkbox"/> POS-0A-30-45-DAWA
16. <input type="checkbox"/> HMO-0A-30-45-DHSA	

#### Pharmacy Options

A.  \$10/\$20/\$35    B.  \$15/\$30/\$40    C.  \$200 Deductible-\$15/\$30/\$40

#### Upfront Deductible Plans – Calendar Year

21. <input type="checkbox"/> HMO-0A-30-45-UAJA	23. <input type="checkbox"/> HMO-0A-30-45-UAGA
22. <input type="checkbox"/> HMO-0A-30-45-UAFA	

#### Pharmacy Options

A.  \$10/\$20/\$35    B.  \$15/\$30/\$40    C.  \$200 Deductible-\$15/\$30/\$40

#### Upfront Deductible Plans – Contract Year

24. <input type="checkbox"/> FlexPOS-30-45-250/500-80%	26. <input type="checkbox"/> FlexPOS-30-45-750/1500-80%
25. <input type="checkbox"/> FlexPOS-30-45-500/1000-80%	27. <input type="checkbox"/> FlexPOS-30-45-1000/2000-80%

#### Pharmacy Option

D.  \$15/\$30/\$40 (50% Out-of-Network Coinsurance)

### CONNECTICARE OF MASSACHUSETTS, INC. (CMI): MA DOMICILED ONLY

#### Hospital Copayment Plans

HMO	POS
47. <input type="checkbox"/> MAH-0A-15-25-AACA	52. <input type="checkbox"/> MAP-0A-15-25-AASA
48. <input type="checkbox"/> MAH-0A-20-30-AACA	53. <input type="checkbox"/> MAP-0A-20-30-AASA
49. <input type="checkbox"/> MAH-0A-20-30-AADA	54. <input type="checkbox"/> MAP-0A-20-30-AHTA
50. <input type="checkbox"/> MAH-0A-30-40-AHUA	55. <input type="checkbox"/> MAP-0A-30-40-AHVA
51. <input type="checkbox"/> MAH-0A-30-40-AADA	56. <input type="checkbox"/> MAP-0A-30-40-ABJA

#### Hospital Deductible Plans

57. <input type="checkbox"/> MAH-0A-20-30-DHWA	58. <input type="checkbox"/> MAH-0A-25-35-DAMA	59. <input type="checkbox"/> MAH-0A-30-40-DBFA
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#### Upfront Deductible Plans-Calendar Year

60. <input type="checkbox"/> MAH-0A-20-30-UHXA	61. <input type="checkbox"/> MAH-0A-25-35-UHYA	62. <input type="checkbox"/> MAH-0A-30-40-UHZA
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#### Pharmacy Options

A.  \$10/\$20/\$35    B.  \$15/\$30/\$40    C.  \$200 Deductible-\$15/\$30/\$40

#### DOMESTIC PARTNER RIDER (Massachusetts plans only)

Yes     No    Note: Affidavits must be received with paperwork.

#### HSA Compatible – Calendar Year: Plan selected includes pharmacy benefit.

HMO	POS
28. <input type="checkbox"/> HMO-0A-00-00-HEVI/HEWF	32. <input type="checkbox"/> POS-0A-00-00-HDZI/HEAF
29. <input type="checkbox"/> HMO-0A-00-00-HEZI/HFAF	33. <input type="checkbox"/> POS-0A-00-00-HEDI/HEEF
30. <input type="checkbox"/> HMO-0A-00-00-HFBI/HFCF	34. <input type="checkbox"/> POS-0A-00-00-HEHI/HEIF
31. <input type="checkbox"/> HMO-0A-00-00-HFDI/HFEF	35. <input type="checkbox"/> POS-0A-00-00-HEJI/HEKF

#### HSA Compatible – Contract Year: Plan selected includes pharmacy benefit.

HMO	POS
36. <input type="checkbox"/> HMO-0A-00-00-HIKI/HILF	40. <input type="checkbox"/> POS-0A-30-45-HHFI/HHGF
37. <input type="checkbox"/> HMO-0A-30-45-HGZI/HHAF	41. <input type="checkbox"/> POS-0A-30-45-HHHI/HHIF
38. <input type="checkbox"/> HMO-0A-30-45-HHBI/HHCF	42. <input type="checkbox"/> POS-0A-30-45-HHJI/HHKF
39. <input type="checkbox"/> HMO-0A-30-45-HHDI/HHEF	

#### HRA PLANS: Available with applicable hospital and upfront deductible plans.

#### PPO (CICI): CT Domiciled Only (Select one ConnectiCare Network USA Plan)

##### HOSPITAL COPAYMENT PLANS

43.  PPO-20-30-A1    44.  PPO-20-30-A2    45.  PPO-30-45-A1

##### HOSPITAL DEDUCTIBLE PLAN

46.  PPO-30-45-D1

#### Pharmacy Options

A.  \$10/\$20/\$35    B.  \$15/\$30/\$40    C.  \$200 Deductible-

#### IF YOU HAVE EMPLOYEES WHO RESIDE IN MASSACHUSETTS AND/OR NEW YORK, PLEASE CHECK ONE OF THE FOLLOWING:

- All employees who reside in Massachusetts, and their dependents, are eligible for the ConnectiCare Network USA PPO Plan.
- All employees who reside in New York, and their dependents, are eligible for the ConnectiCare Network USA PPO Plan.

#### and/or

- Only Massachusetts employees residing in Massachusetts but outside the ConnectiCare of Massachusetts, Inc. (CMI) service area (Hampden, Hampshire & Franklin Counties) are eligible for the ConnectiCare Network USA Plan for themselves and their dependents. Employees who reside in the CMI service area will be enrolled in CCI products for themselves and their dependents.
- Only New York employees residing in New York but outside the ConnectiCare of New York, Inc. (CNY) service area (Orange, Putnam, Rockland and Westchester counties) are eligible for the ConnectiCare Network USA Plan for themselves and their dependents. Employees who reside in the CNY service area will be enrolled in CCI products for themselves and their dependents.

#### Dual or Triple Option

Plan # \_\_\_\_\_ Rx \_\_\_\_\_    Plan # \_\_\_\_\_ Rx \_\_\_\_\_

Plan # \_\_\_\_\_ Rx \_\_\_\_\_

Indicate sold plan number and Rx letter for all CT and/or MA domiciled plans.

#### ConnectiCare Dental Plans: CT Domiciled Only For groups with 5 or more ees.

##### NETWORK

Value     Plus     Premium

##### PLAN

\$1,000 benefit maximum     \$1,500 benefit maximum (10+ ees only)

with orthodontia (10+ ees only)

##### DOMESTIC PARTNER (Dental only)

Yes     No    Note: Affidavit must be received with paperwork.



White-ConnectiCare / Yellow-Agent/Broker