

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 Physician  Change Division  
 COBRA Election  Other (Name change, address change, etc. Indicate reason for change.) \_\_\_\_\_

Plan type:  HMO  Point-of-Service (POS)

Plan Name: (from Benefit Summary) \_\_\_\_\_

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 Physician	ConnectiCare Provider ID Number	Existing Patient
Employee			____ - ____ - _____	<input type="checkbox"/> M <input type="checkbox"/> F	/ /			<input type="checkbox"/> Yes <input type="checkbox"/> No
Spouse/Civil Union/Domestic Partner			____ - ____ - _____	<input type="checkbox"/> M <input type="checkbox"/> F	/ /			<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent 1			____ - ____ - _____	<input type="checkbox"/> M <input type="checkbox"/> F	/ /			<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent 2			____ - ____ - _____	<input type="checkbox"/> M <input type="checkbox"/> F	/ /			<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent 3			____ - ____ - _____	<input type="checkbox"/> M <input type="checkbox"/> F	/ /			<input type="checkbox"/> Yes <input type="checkbox"/> No

**Race/Ethnicity (optional):**

This information is designed for the purpose of data collection and will not be used to determine eligibility, premium rate 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 \_\_\_\_\_ Policy Number \_\_\_\_\_ Medicare (Please attach a copy of your Medicare card.)  
(Please attach a copy of your group medical insurance card.)  Part A  Part B  Retired

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

COBRA  Yes  No Length of coverage:  18 months  36 months  Other \_\_\_\_\_ Date of Hire (mm/dd/yy) \_\_\_\_\_ 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 of Massachusetts, Inc. (CMI) or a CMI 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 CMI'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 CMI 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 CMI 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 CMI as long as CMI 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.

### **ELIGIBILITY REQUIREMENTS FOR DEPENDENT CHILDREN AGE 20 OR OLDER**

**To be eligible for dependent coverage, your child must be:**

- 1. A child under age 26, who you are claiming as an IRS dependent this year, or:**
- 2. A child under age 26, who lost IRS dependent status less than two years ago, or:**
- 3. A child under age 26, who is a full-time student at a recognized college, university or trade school accredited by its corresponding trade or professional organization, or approved by the State Department of Education.**

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, premium rate 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?**