



### **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 Insurance Company, Inc. (CICI) or a CICI-affiliate, 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 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 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 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. I understand that I can revoke this authorization (but will be terminated from the Plan) at any time by giving written notice to CICI as long as 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.

### **INSTRUCTIONS FOR ENROLLING A FULL-TIME STUDENT DEPENDENT AGE 19 OR OLDER**

Please enclose a copy of one of the following documents with your Enrollment/Change Form:

- 1. The front and back of a canceled tuition check for the current semester.**
- 2. A dated class schedule for the current semester with the student's name on it.**
- 3. A paid tuition invoice for the current semester.**
- 4. A signed loan agreement for the current semester tuition costs.**

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?**