

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: FlexPOS PPO (for PPO product, identification of PCP, provider ID# and existing patient info not required) Other

Employee's Social Security Number _____ Marital Status: Single Married/Civil Union 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 (optional) _____ Primary Language (optional) _____

MEMBER(S): First Name/Middle Initial/Last Name	Add	Delete	Member Identification Number (existing members only)	Sex	Date of Birth (mm/dd/yy)	Full-Time Student*	Primary Care Physician	Provider ID Number (8 digits)	Existing Patient
Employee			_____	<input type="checkbox"/> M <input type="checkbox"/> F	/ /			_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Spouse			_____	<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		_____	<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		_____	<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		_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent 4			_____	<input type="checkbox"/> M <input type="checkbox"/> F	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No		_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Check if enrolling a disabled dependent age 19 or over and contact ConnectiCare to obtain a form for submitting proof of disability. ***See instructions on back.**

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 _____ Social Security Number _____ 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) / /

Group Number/Division _____ Group Name _____ Employee Work Location _____ Plan Description _____

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 and you agree to keep it confidential. This authorization is valid as long as you are enrolled in a ConnectiCare health plan. 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 Insurance Company, Inc., (CICI) or a CICI affiliated, or other organization or person having records, data or 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 understand that the pink copy attached is my 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.**

INSTRUCTIONS: DID YOU REMEMBER TO ...

- Print clearly, complete all sections and sign at the bottom of page 1?**
- Select your primary care physician and include the 8-digit 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?**
- Attach proof of full-time student status?**