

IMPORTANT: Directions

1. In order to ensure that your group receives its ID cards/member materials for the requested effective date, we require a 15th 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 15th of the month are not guaranteed approval for the requested effective date.
2. Participation:
 - Groups of 2-9, 75% minimum participation is required of all eligible employees.
 - Groups of 10-50, 65% minimum participation is required of all eligible employees.
 - POS and FlexPOS plans require 70% of eligible enrollees to live in the ConnectiCare service area.
 - Waiver Forms are used in conjunction with Enrollment Forms to calculate participation.
3. Small Group Application:
 - Employer is required to read, complete, date, and sign the Application indicating Medical Plan Option, Pharmacy Option and Dental Plan Option choices. Subsequent plan changes are available only on group renewal date.
 - Please select a new hire waiting period (can select zero.)
 - Agent Information must be completely filled out, including the tax ID #'s. Agents must be licensed and appointed with ConnectiCare.
4. Each enrolling employee must fully complete, date, and sign all sections of the ConnectiCare Enrollment/Change Form. Please indicate a PCP; please remember to complete the date of birth.
5. Each enrolling employee must complete, date and sign the “Family Health Statement.”
 - All “yes” answers must be explained (on front and back).
 - Number of hours worked and date of hire must be completed on Family Health Statement
6. Employers are required to submit proof of employment for all employees wishing to enroll in the group plan. Acceptable proof of employment includes:
 - Employee is listed on the quarterly tax-and-wage report; or
 - Proof of income paid via copies of cleared checks issued by the employer.
7. Tax documents: Please submit the most recent tax information described below. NOTE: Payroll journals are not acceptable. Please indicate employees’ status (full-time, part-time, waiving, etc.) on this form. Everyone on tax documentation must be accounted for: # of waivers + # of enrollment forms = total eligibles.
 - A. Sole proprietor and single owner LLC: Schedule C. If employees; most recent state quarterly earnings report (UC-5A/UC-2.)
 - B. Multiple owners/Partnership(s): 1065 with K-1’s for all partners totaling 100% ownership. If employees; most recent state quarterly earnings report (UC-5A/UC-2.)
 - C. Corporation: Form 1120C or 1120S. If employees; most recent state quarterly earnings report (UC-5A/UC-2.)
 - D. Non-Profit with employees: most recent state quarterly earnings report (UC-5A/UC-2.)
 - E. New Business: New Business Certification Statement with a copy of federal EIN notification letter or Sales & Use Tax Permit (if applicable).
8. Please submit first month’s premium, payable via *business* check, to ConnectiCare.

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

- Small-Group Employer Application **dated and signed** with
 - Medical Plan Option
 - Pharmacy Option
 - Dental Plan Option
 - New Hire Waiting Period Option
- Waiver form: Waivers must indicate number of hours worked and date of hire. (Please submit on ConnectiCare’s Waiver Form.)
- ConnectiCare Enrollment/Change Forms **dated and signed**
- Completed Family Health Statements for every eligible enrolling employee **dated and signed**
- Copy of **most recent Tax Filing State Quarterly Wage & Tax Form.**
 - Please indicate employee’s status (full-time, part-time, waiving, etc.) on this form.*
- Copy of the current carrier bill
- Copy of complete quote with employee census
- First Month’s Premium — **Please make business check payable to ConnectiCare.**
- Coinsurance Funding Attestation

Submit all paperwork to: ConnectiCare Small-Group Sales, P.O. Box 4050, 175 Scott Swamp Road, Farmington, CT 06034-4050.
Please do not mail your application directly to your Sales Representative’s attention; doing so will delay your application.



Company Information

1. Desired Effective Date _____ Small Group # _____ ConnectiCare use only
2. Legal Business Name _____
3. DBA/Doing Business As (if applicable) _____
4. Physical Address _____ P.O. Box _____
 City _____ State _____ ZIP _____ Phone () _____ Fax () _____
5. Nature of Business _____ Billing/Contact Person _____
6. Organization Type Corporation Partnership Sole Proprietorship Other _____
7. Federal Tax Identification Number _____ Business Effective Date _____ Current Ownership Date _____
8. Do you offer health coverage to employees working 20-29 hours? Yes No
9. Are you affiliated with any other company? Yes No If yes, relationship type _____
 Name of affiliated company _____ Relationship effective date _____ Total number of employees _____
10. Number of full-time eligible employees working 30 hours or more per week _____ Number of enrolling employees _____
 Number of spousal/applicable waivers _____ Number of "other" waivers _____
 Number of part-time employees working 20-29 hours per week _____ Number of part-time employees working less than 20 hours per week _____
 Number of seasonal employees _____ Number of former employees on COBRA/state continuation _____
 Total number of employees (including owners, part-time and seasonal) _____
11. New Hire Waiting Period 0 30 60 90 180 Days First of month following new hire waiting period selected
12. Will coverage be transferring from another carrier? Yes No
 If yes, prior carrier name _____ Proposed termination date _____
 (Please include a copy of the current premium bill with this carrier.)
 If prior carrier is ConnectiCare, provide group #: _____ Total replacement? Yes No
 Has the group been uninsured for three or more months prior to the requested effective date? Yes No
13. Small Employer Certification: *Pursuant to state law, carriers need information from an employer to determine if the employer qualifies as a small employer under the law. Guaranteed issue and renewability and ConnectiCare's underwriting guidelines are contingent upon this criteria being met. Certification of eligibility is required herein and prior to renewal. Your group health plan will become effective only as approved by ConnectiCare.* I hereby certify the employer applying for coverage is a small group under applicable state law. 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 eligible employees have equal access to ConnectiCare coverage. 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. I acknowledge that ConnectiCare reserves the right to request any reasonable documentation from the employer, its affiliates, subscribers or dependents in order to verify eligibility.
- Employer Signature _____ Title _____ Date _____
 E-mail Address _____

Agent Information

14. Agency Name _____ Agent Name _____
15. Address _____ City _____ State _____ ZIP _____
 Phone () _____ Fax () _____ Commission Paid to: Agency Agent
 Social Security # or Tax ID # _____ Must be completed to ensure proper commission payment. ConnectiCare Appointment Yes No
 Contact Person _____ Agent E-mail Address _____
16. 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 if I 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 _____ Date _____

**Submit all paperwork to: ConnectiCare Small-Group Sales, P.O. Box 4050, 175 Scott Swamp Road, Farmington, CT 06034-4050.
 Please do not mail your application directly to your Sales Representative's attention; doing so will delay your application.**



Connecticare, Inc. (CCI): Connecticut Domiciled Only

Hospital Copayment Plans (Calendar Year Plans)

- | | |
|---|--|
| 1. <input type="checkbox"/> HMO-0A-15/25-100D-CAL | 8. <input type="checkbox"/> POS-0A-15/25-100D-CAL |
| 2. <input type="checkbox"/> HMO-0A-15/30-100D-CAL | 9. <input type="checkbox"/> POS-0A-20/30-250D-CAL |
| 3. <input type="checkbox"/> HMO-0A-20/30-250D-CAL | 10. <input type="checkbox"/> POS-0A-20/30-500D-CAL |
| 4. <input type="checkbox"/> HMO-0A-20/30-500D-CAL | 11. <input type="checkbox"/> POS-0A-30/45-500D-CAL |
| 5. <input type="checkbox"/> HMO-0A-20/35-500A-CAL | |
| 6. <input type="checkbox"/> HMO-0A-30/45-250D-CAL | |
| 7. <input type="checkbox"/> HMO-0A-30/45-500D-CAL | |

Hospital Deductible Plans (Calendar and Contract Year Plans)

- | | |
|---|---|
| 12. <input type="checkbox"/> HMO-0A-15/25-1500HospDed-CAL | 25. <input type="checkbox"/> POS-0A-15/25-1500HospDed-CAL |
| 13. <input type="checkbox"/> HMO-0A-20/30-2500HospDed-CAL | 26. <input type="checkbox"/> POS-0A-20/30-2500HospDed-CAL |
| 14. <input type="checkbox"/> HMO-0A-30/45-1500HospDed-CAL | 27. <input type="checkbox"/> POS-0A-20/30-3000HospDed-CAL |
| 15. <input type="checkbox"/> HMO-0A-30/45-2000HospDed-CAL | 28. <input type="checkbox"/> POS-0A-30/45-1500HospDed-CAL |
| 16. <input type="checkbox"/> HMO-0A-30/45-2500HospDed-CAL | 29. <input type="checkbox"/> POS-0A-30/45-2500HospDed-CAL |
| 17. <input type="checkbox"/> HMO-0A-30/45-5000HospDed-CAL | 30. <input type="checkbox"/> POS-0A-30/45-3000HospDed-CAL |
| 18. <input type="checkbox"/> HMO-0A-15/25-1500HospDed-CNT | 31. <input type="checkbox"/> POS-0A-15/25-1500HospDed-CNT |
| 19. <input type="checkbox"/> HMO-0A-20/30-1500HospDed-CNT | 32. <input type="checkbox"/> POS-0A-20/30-2500HospDed-CNT |
| 20. <input type="checkbox"/> HMO-0A-20/30-2500HospDed-CNT | 33. <input type="checkbox"/> POS-0A-20/30-3000HospDed-CNT |
| 21. <input type="checkbox"/> HMO-0A-30/45-1500HospDed-CNT | 34. <input type="checkbox"/> POS-0A-30/45-1500HospDed-CNT |
| 22. <input type="checkbox"/> HMO-0A-30/45-2000HospDed-CNT | 35. <input type="checkbox"/> POS-0A-30/45-2500HospDed-CNT |
| 23. <input type="checkbox"/> HMO-0A-30/45-2500HospDed-CNT | 36. <input type="checkbox"/> POS-0A-30/45-3000HospDed-CNT |
| 24. <input type="checkbox"/> HMO-0A-30/45-5000HospDed-CNT | |

Upfront Deductible Plans (Calendar and Contract Year Plans)

- | | |
|---|---|
| 37. <input type="checkbox"/> HMO-0A-1500Upfront-30/45-CAL | 43. <input type="checkbox"/> POS-0A-30/45-3000Ded-CAL |
| 38. <input type="checkbox"/> HMO-0A-2500Upfront-30/45-CAL | 44. <input type="checkbox"/> POS-0A-1500Upfront-30/45-CNT |
| 39. <input type="checkbox"/> HMO-0A-5000Upfront-30/45-CAL | 45. <input type="checkbox"/> POS-0A-2500Upfront-30/45-CAL |
| 40. <input type="checkbox"/> HMO-0A-1500Upfront-30/45-CNT | 46. <input type="checkbox"/> POS-0A-30/45-3000Ded-CNT |
| 41. <input type="checkbox"/> HMO-0A-2500Upfront-30/45-CNT | 47. <input type="checkbox"/> POS-0A-30/45-3500Ded-CNT |
| 42. <input type="checkbox"/> HMO-0A-5000Upfront-30/45-CNT | |

Pharmacy Options

- A. \$10/\$20/\$35 B. \$15/\$30/\$40
 C. \$15/\$30/\$40 with a \$200 Calendar or Contract Year Deductible
 D. \$15/50%/50% \$200 Deductible T2/T3 \$100 per script max

FLEX POS PLANS Contract Year Plans

Hospital Copayment Plans

48. FlexPOS-20/30-500D-CNT 49. FlexPOS-30/45-500D-CNT

Hospital Deductible Plans

50. FlexPOS-20/35-2500HospDed-CNT 51. FlexPOS-30/45-1500HospDed-CNT

Upfront Deductible Plans

- | | |
|---|--|
| 52. <input type="checkbox"/> FlexPOS-20/30-3000Ded-10%-CNT | 57. <input type="checkbox"/> FlexPOS-1000Upfront-30/45-80%-CNT |
| 53. <input type="checkbox"/> FlexPOS-30/45-2500Ded-10%-CNT | 58. <input type="checkbox"/> FlexPOS-1250Upded-30/45-80%-CNT |
| 54. <input type="checkbox"/> FlexPOS-250Upfront-30/45-80%-CNT | 59. <input type="checkbox"/> FlexPOS-750Upded-80%-CNT |
| 55. <input type="checkbox"/> FlexPOS-500Upfront-30/45-80%-CNT | |
| 56. <input type="checkbox"/> FlexPOS-750Upfront-30/45-80%-CNT | |

Pharmacy Options

- E. \$15/\$30/\$40 (50% Out-of-Network Coinsurance)
 F. \$15/\$30/\$40 with \$200 Deductible (50% Out-of-Network Coinsurance)
 G. \$15/50%/50% \$200 Deductible T2/T3 \$100 per script max

Other plan: _____

The following information is being provided in accordance with the recent Connecticut State mandate (SB 46, PA 09-46), which requires Medical Loss Ratio (MLR) disclosure by all insurance companies.

Medical Loss Ratio for calendar year 2010: ConnectiCare, Inc. (CCI) **79.5%**
 The medical loss ratio is defined as the ratio of incurred claims to earned premium for the prior calendar year for managed care plans issued in Connecticut and is calculated in accordance with Connecticut law.

HSA COMPATIBLE PLANS

Calendar Year Plans

- | | |
|---|---|
| 60. <input type="checkbox"/> HMO-0A-HSA-2500I/5000F-CAL | 65. <input type="checkbox"/> POS-0A-HSA-3500I/7000F-CAL |
| 61. <input type="checkbox"/> HMO-0A-HSA-3500I/7000F-CAL | 66. <input type="checkbox"/> POS-0A-HSA-5000I/10000F-CAL |
| 62. <input type="checkbox"/> HMO-0A-HSA-5000I/10000F-CAL | 67. <input type="checkbox"/> POS-0A-HSA-1500I/3000F-15/25-CAL |
| 63. <input type="checkbox"/> HMO-0A-HSA-1500I/3000F-15/25-CAL | 68. <input type="checkbox"/> FlexPOS-HSA-1500I/3000F-10%-CAL |
| 64. <input type="checkbox"/> POS-0A-HSA-2500I/5000F-CAL | 69. <input type="checkbox"/> FlexPOS-HSA-2500I/5000F-10%-CAL |

Contract Year Plans

- | | |
|---|--|
| 70. <input type="checkbox"/> HMO-0A-HSA-2500I/5000F-CNT | 79. <input type="checkbox"/> POS-0A-HSA-3500I/7000F-CNT |
| 71. <input type="checkbox"/> HMO-0A-HSA-3500I/7000F-CNT | 80. <input type="checkbox"/> POS-0A-HSA-5000I/10000F-CNT |
| 72. <input type="checkbox"/> HMO-0A-HSA-5000I/10000F-CNT | 81. <input type="checkbox"/> POS-0A-HSA-1500I/3000F-15/25-CNT |
| 73. <input type="checkbox"/> HMO-0A-HSA-1500I/3000F-15/25-CNT | 82. <input type="checkbox"/> POS-0A-HSA-1500I/3000F-30/45-CNT |
| 74. <input type="checkbox"/> HMO-0A-HSA-2000I/4000F-15/25-CNT | 83. <input type="checkbox"/> POS-0A-HSA-2000I/4000F-30/45-CNT |
| 75. <input type="checkbox"/> HMO-0A-HSA-1500I/3000F-30/45-CNT | 84. <input type="checkbox"/> POS-0A-HSA-2500I/5000F-30/45-CNT |
| 76. <input type="checkbox"/> HMO-0A-HSA-2000I/4000F-30/45-CNT | 85. <input type="checkbox"/> FlexPOS-HSA-2000I/4000F-15/25-CNT |
| 77. <input type="checkbox"/> HMO-0A-HSA-2500I/5000F-30/45-CNT | 86. <input type="checkbox"/> FlexPOS-HSA-1500I/3000F-10%-CNT |
| 78. <input type="checkbox"/> POS-0A-HSA-2500I/5000F-CNT | 87. <input type="checkbox"/> FlexPOS-HSA-2500I/5000F-10%-CNT |

All HSA Compatible Plans include Pharmacy Benefits

POS Coinsurance Plans (Contract Year Plans)

- | | |
|---|---|
| 88. <input type="checkbox"/> POS-Upfront 1000-30PCP-50%-CNT | 91. <input type="checkbox"/> POS-Upfront 1000-30PCP-25%-CNT |
| 89. <input type="checkbox"/> POS-Upfront 2500-30PCP-50%-CNT | 92. <input type="checkbox"/> POS-Upfront 2500-30PCP-25%-CNT |
| 90. <input type="checkbox"/> POS-Upfront 3500-30PCP-50%-CNT | 93. <input type="checkbox"/> POS-Upfront 750-50%-CNT |

Pharmacy Option

- H. \$15/50%/50% \$200 Deductible T2/T3 \$100 per script max
 I. \$15/\$30/\$40 with a \$200 Contract Year Deductible

DUAL OR TRIPLE OPTION

Offering Calendar Year and Contract Year plans side by side is not recommended. Not available for HRA Compatible Plans.

Plan # _____ Rx _____ Plan # _____ Rx _____
 Plan # _____ Rx _____
 Indicate sold plan number and Rx letter for all CT domiciled plans.

Premium \$ _____ Check # _____
 Composite Rated (Group 25-50 in Connecticut)

ConnectiCare Dental Plans (for groups with three or more employees)

NETWORK Value Plus Premium

PLAN

- \$1,000 benefit maximum \$1,500 benefit maximum (10+ ees only.)
 Basic Plan (10+ ees) Basic Plan (3-9 ees) 3-9 Comprehensive Plan

with orthodontia (10+ ees only.) Not applicable to Basic Plans.

DOMESTIC PARTNER (Dental only)

- Yes No Note: Affidavit must be received with paperwork.

SIC CODE:

Submit all paperwork to: ConnectiCare Small-Group Sales, P.O. Box 4050, 175 Scott Swamp Road, Farmington, CT 06034-4050.
 Please do not mail your application directly to your Sales Representative's attention; doing so will delay your application.



Coverage is provided by and services are administered as follows: In Connecticut: Group HMO and POS coverage is underwritten by ConnectiCare, Inc. FlexPOS, ASO/Self-funded services, and Dental products are administered or underwritten by ConnectiCare Insurance Company, Inc.



SMALL-GROUP ATTESTATION REGARDING EMPLOYER FUNDING OF DEDUCTIBLE OR COINSURANCE PLANS

ConnectiCare is committed to providing clients with affordable health insurance options for their employees. Inherent in the pricing of ConnectiCare’s deductible plans (both up-front deductible and hospital deductible plans) and its coinsurance plans is an actuarial assumption that the members will be responsible consumers of medical care and will be liable for the intended member out-of-pocket expenses.

To maintain the integrity of the pricing of the deductible products, ConnectiCare is requiring that an officer of the company and the company’s agent-of-record attest to the employer’s strategy for funding any portion of the employees’ out-of-pocket medical expense exposure. The employer funding strategy will impact the pricing of these plans.

Please indicate your deductible plan funding strategy below:

Note: ConnectiCare underwriting guidelines do not allow any employer funding on 50/50 coinsurance plans.

1) No employer funding of an FSA, HRA, HSA or any other self-funded mechanism _____

2) Annual employer contribution to an FSA, HRA, HSA or some other self-funded mechanism is:

\$_____ Employee \$_____ Family

3) Additional details (i.e. employer funding is tied to participation in wellness program; funding varies by employee salary; etc.) Please be specific in your explanation:

By signing below you are indicating that you will notify us immediately if you are currently using or if you intend to use an underlying plan to subsidize your employees’ cost sharing responsibilities, or if you are changing the funding strategy noted above. ConnectiCare reserves the right to adjust rates retroactively, reduce agent commissions, and/or rescind the coverage for non-compliance with this underwriting rule.

Employer

Agent of Record

Group Number

Signature of Agent

Signature of Officer

Date

Title

Date

Coverage is provided by and services are administered as follows: In Connecticut: Group HMO and POS coverage, and Individual HMO coverage is underwritten by ConnectiCare, Inc.; Group coverage for coinsurance plans and Individual POS coverage is underwritten by ConnectiCare Insurance Company, Inc. In Massachusetts: Group HMO and POS coverage is underwritten by ConnectiCare of Massachusetts, Inc. FlexPOS, PPO coverage, ASO/Self-funded services, and Dental products are administered or underwritten by ConnectiCare Insurance Company, Inc.