

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 Provider 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 Provider	ConnectiCare Provider ID Number (optional)	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

Are you currently using tobacco?

Employee Yes No Spouse/Civil Union/Dom. Partner Yes No Dependent 1 Yes No Dependent 2 Yes No Dependent 3 Yes No

Race/Ethnicity (optional):

This information is designed for the purpose of data collection and will not be used to determine eligibility, rating 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:

Will you have other health insurance in addition to this ConnectiCare plan, under a Group, HMO or Medicare plan? Yes No

If yes, name of person covered _____

Employer _____

Insurance Co. Name and Address (Please attach a copy of your group medical insurance card.) _____

Policy Number _____

Medicare (Please attach a copy of your Medicare card.) _____

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) ____/____/____ Hours per week ____/____ 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.

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?**