ConnectiCare®

Small Group Information Change Form

Effective Date of Change: _____
Group Number: _____
Group Name: _____

Please select the change requested.

- ❑ **Change of Address**
  Current Address:

  _____

  _____

  _____

  Phone #:_____Fax #:_____

  New Address: ❑ Check if for Billing Purposes only

  _____

  _____

  _____

  Phone #:_____Fax #:_____

  E-mail: _____

- ❑ **Change of Contact**
  Please check if for: ❑ Billing ❑ Group ❑ Both

  Old Contact Name: _____

  New Contact Name: _____

- ❑ **Termination of Group -** In compliance with your Group Contract, a minimum of 30 days advance notification is required.

  Effective Date of Termination: _____
  (Must be end of Month, e.g. 8/31/03)

  Reason for Termination: _____

Signature: _____ **Date:**_____
Printed Name: _____
Position:_____

Please mail form to:
ConnectiCare, Inc. & Affiliates, Attn.: Billing Department,
175 Scott Swamp Road, Farmington, CT 06032-3124
Or Fax to : (860) 678-5255, Attn.: Billing Department