ConnectiCare

175 Scott Swamp Rd., Farmington, CT 06032
Fax: 860-678-5281

Large Group Fixed Funding Solutions Enrollment/Change Form

Please print clearly. Complete in full using a pen.

EMPLOYER: If enrolling under a group plan, form cannot be processed without this information. Non-group enrollees, skip to next section.

Group Name	Employee Work Location	Group Number

Date of Hire (mm/dd/yy)	Hours Per Week	Coverage Effective Date (mm/dd/yy)	Coverage End Date (mm/dd/yy)	COBRA: ☐ Yes ☐ No	COBRA Start Date (mm/dd/yy) _____ COBRA End Date (mm/dd/yy) _____	Length of coverage: ☐ 18 months ☐ Other _____

Employer Signature	Title	Date

SUBSCRIBER/EMPLOYEE: Complete the following sections, sign at bottom, and read information on reverse side.

Please check appropriate item: ☐ New Enrollment ☐ Cancel Enrollment ☐ Add Dependent ☐ Remove Dependent ☐ Change Plan ☐ COBRA Election
☐ Other (Name change, address change, etc. Indicate reason for change.)

First Name	Middle Name	Last Name

Street Address	City	State	ZIP Code

Primary Phone Number: ☐ Home ☐ Cell ☐ Work	Secondary Phone Number: ☐ Home ☐ Cell ☐ Work	Email Address	Primary Language (optional)

Marital Status: ☐ Single ☐ Married/Civil Union ☐ Domestic Partner ☐ Legally Separated ☐ Separated ☐ Divorced ☐ Widowed

2025 Large Group Fixed Funding Plans

☐ FLEX HSA $5,000 20%
☐ FLEX HSA $6,000 10%
☐ FLEX HSA $4,000 20%
☐ FLEX HSA $3,300 25%
☐ FLEX HSA $5,000
☐ FLEX HSA $2,500
☐ FLEX HSA $1,650
☐ FLEX HSA $2,000 10%

2025 Copay/Coinsurance Plans:

☐ FLEX $5,000 20%
☐ FLEX $30 $2,500 50%
☐ FLEX $30 $2,500 20%
☐ FLEX $35/50 $4,000 20%
☐ FLEX $30/50 $3,500 20%
☐ FLEX $30/45 $5,000
☐ FLEX $30/50 $2,000
☐ FLEX $30/45 $1,500
☐ FLEX $30/45 $500 $500 Day

Subscriber/Dependents	Add	Remove	Social Security Number (required)	Birth Sex: What sex were you assigned at birth?	Gender Identity: What is your current gender identity?	Date of Birth (mm/dd/yy)	Primary Care Provider
Applicant/Subscriber (First Name/Middle Initial/Last Name)	☐	☐		☐ M ☐ F ☐ Gender X ☐ Unknown	☐ M ☐ F ☐ Transgender male/female-to-male (FTM) ☐ Transgender female/male-to-female (MTF) ☐ Non-binary/gender X/genderqueer or third gender ☐ Other: Prefer to self describe ☐ Choose not to disclose		
Spouse/Civil Union/Domestic Partner* (First Name/Middle Initial/Last Name)	☐	☐		☐ M ☐ F ☐ Gender X ☐ Unknown	☐ M ☐ F ☐ Transgender male/female-to-male (FTM) ☐ Transgender female/male-to-female (MTF) ☐ Non-binary/gender X/genderqueer or third gender ☐ Other: Prefer to self describe ☐ Choose not to disclose		
Dependent 1 (First Name/Middle Initial/Last Name)	☐	☐		☐ M ☐ F ☐ Gender X ☐ Unknown	☐ M ☐ F ☐ Transgender male/female-to-male (FTM) ☐ Transgender female/male-to-female (MTF) ☐ Non-binary/gender X/genderqueer or third gender ☐ Other: Prefer to self describe ☐ Choose not to disclose		
Dependent 2 (First Name/Middle Initial/Last Name)	☐	☐		☐ M ☐ F ☐ Gender X ☐ Unknown	☐ M ☐ F ☐ Transgender male/female-to-male (FTM) ☐ Transgender female/male-to-female (MTF) ☐ Non-binary/gender X/genderqueer or third gender ☐ Other: Prefer to self describe ☐ Choose not to disclose		
Dependent 3 (First Name/Middle Initial/Last Name)	☐	☐		☐ M ☐ F ☐ Gender X ☐ Unknown	☐ M ☐ F ☐ Transgender male/female-to-male (FTM) ☐ Transgender female/male-to-female (MTF) ☐ Non-binary/gender X/genderqueer or third gender ☐ Other: Prefer to self describe ☐ Choose not to disclose		

☐ Check if enrolling a disabled dependent age 26 and over. Please complete the Disabled Dependent Application Form and return with your enrollment.

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

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.) ☐ Part A ☐ Part B ☐ Retired

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. To the best of my knowledge and belief, I certify that the information supplied in the form is correct. I agree to the consent on the reverse side of this form. I understand that the phone numbers I provided on this application may be used by ConnectiCare or any of its contracted parties to contact me about my account, the provision of services to me, or my health benefit plan or related programs.

▶ Subscriber/Employee's Signature _____ Date _____

MEMBER DEMOGRAPHIC DATA (Required) This information is designed for the purpose of data collection and will not be used to determine eligibility, rating, or claim payment.

Employee

Pronouns: What are your pronouns? ☐ He/him ☐ She/her ☐ They/them ☐ Choose not to disclose

Sexual Orientation: Which of the following best describes you? ☐ Straight or heterosexual ☐ Lesbian or gay ☐ Bisexual ☐ Queer, pansexual, and/or questioning ☐ Don't Know ☐ Other option not specified (something else) ☐ Choose not to disclose

Accessible Format: ☐ Not applicable ☐ B - Braille ☐ L - Large Print ☐ A - Audio CD ☐ Choose not to disclose

Ethnicity: Are you of Hispanic, Latino/a, or Spanish origin? ☐ No, not of Hispanic, Latino/a, or Spanish origin ☐ Yes, Puerto Rican ☐ Yes, Dominican ☐ Yes, Mexican, Mexican American, Chicano/a ☐ Yes, Other Hispanic, Latino/a, or Spanish origin ☐ Yes, Cuban ☐ Choose not to disclose

Race: Which category best describes your race? ☐ White ☐ Black or African American ☐ Asian Indian ☐ American Indian/Alaska Native ☐ Native Hawaiian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Samoan ☐ Guamanian or Chamorro ☐ Other Pacific Islander ☐ Middle Eastern/North African ☐ Two or more races ☐ Some other race ☐ Choose not to disclose

Language: What is your preferred language? ☐ English ☐ Spanish ☐ Chinese/Cantonese ☐ Chinese/Mandarin ☐ Russian ☐ French Creole (Haitian Creole) ☐ Bengali ☐ Yiddish ☐ French ☐ Italian ☐ Korean ☐ Arabic ☐ Polish ☐ Tagalog ☐ Greek ☐ Albanian ☐ Urdu ☐ Vietnamese ☐ Portuguese ☐ Hindi ☐ American Sign Language ☐ Other language ☐ Choose not to disclose

Spouse

Pronouns: What are your pronouns? ☐ He/him ☐ She/her ☐ They/them ☐ Choose not to disclose

Sexual Orientation: Which of the following best describes you? ☐ Straight or heterosexual ☐ Lesbian or gay ☐ Bisexual ☐ Queer, pansexual, and/or questioning ☐ Don't Know ☐ Other option not specified (something else) ☐ Choose not to disclose

Accessible Format: ☐ Not applicable ☐ B - Braille ☐ L - Large Print ☐ A - Audio CD ☐ Choose not to disclose

Ethnicity: Are you of Hispanic, Latino/a, or Spanish origin? ☐ No, not of Hispanic, Latino/a, or Spanish origin ☐ Yes, Puerto Rican ☐ Yes, Dominican ☐ Yes, Mexican, Mexican American, Chicano/a ☐ Yes, Other Hispanic, Latino/a, or Spanish origin ☐ Yes, Cuban ☐ Choose not to disclose

Race: Which category best describes your race? ☐ White ☐ Black or African American ☐ Asian Indian ☐ American Indian/Alaska Native ☐ Native Hawaiian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Samoan ☐ Guamanian or Chamorro ☐ Other Pacific Islander ☐ Middle Eastern/North African ☐ Two or more races ☐ Some other race ☐ Choose not to disclose

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Dependent 1

Pronouns: What are your pronouns? ☐ He/him ☐ She/her ☐ They/them ☐ Choose not to disclose

Sexual Orientation: Which of the following best describes you? ☐ Straight or heterosexual ☐ Lesbian or gay ☐ Bisexual ☐ Queer, pansexual, and/or questioning ☐ Don't Know ☐ Other option not specified (something else) ☐ Choose not to disclose

Accessible Format: ☐ Not applicable ☐ B - Braille ☐ L - Large Print ☐ A - Audio CD ☐ Choose not to disclose

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Race: Which category best describes your race? ☐ White ☐ Black or African American ☐ Asian Indian ☐ American Indian/Alaska Native ☐ Native Hawaiian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Samoan ☐ Guamanian or Chamorro ☐ Other Pacific Islander ☐ Middle Eastern/North African ☐ Two or more races ☐ Some other race ☐ Choose not to disclose

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Dependent 2

Pronouns: What are your pronouns? ☐ He/him ☐ She/her ☐ They/them ☐ Choose not to disclose

Sexual Orientation: Which of the following best describes you? ☐ Straight or heterosexual ☐ Lesbian or gay ☐ Bisexual ☐ Queer, pansexual, and/or questioning ☐ Don't Know ☐ Other option not specified (something else) ☐ Choose not to disclose

Accessible Format: ☐ Not applicable ☐ B - Braille ☐ L - Large Print ☐ A - Audio CD ☐ Choose not to disclose

Ethnicity: Are you of Hispanic, Latino/a, or Spanish origin? ☐ No, not of Hispanic, Latino/a, or Spanish origin ☐ Yes, Puerto Rican ☐ Yes, Dominican ☐ Yes, Mexican, Mexican American, Chicano/a ☐ Yes, Other Hispanic, Latino/a, or Spanish origin ☐ Yes, Cuban ☐ Choose not to disclose

Race: Which category best describes your race? ☐ White ☐ Black or African American ☐ Asian Indian ☐ American Indian/Alaska Native ☐ Native Hawaiian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Samoan ☐ Guamanian or Chamorro ☐ Other Pacific Islander ☐ Middle Eastern/North African ☐ Two or more races ☐ Some other race ☐ Choose not to disclose

Language: What is your preferred language? ☐ English ☐ Spanish ☐ Chinese/Cantonese ☐ Chinese/Mandarin ☐ Russian ☐ French Creole (Haitian Creole) ☐ Bengali ☐ Yiddish ☐ French ☐ Italian ☐ Korean ☐ Arabic ☐ Polish ☐ Tagalog ☐ Greek ☐ Albanian ☐ Urdu ☐ Vietnamese ☐ Portuguese ☐ Hindi ☐ American Sign Language ☐ Other language ☐ Choose not to disclose

IMPORTANT: EMPLOYEE/MEMBER CONSENT

On my behalf and on behalf of my spouse and/or dependent(s), I hereby authorize any doctor, hospital, provider, insurer, ConnectiCare Insurance Company, Inc. 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 administer the plan and that CICI is not required to agree to the requested restrictions. I understand that this authorization is valid for the term of my family's 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.

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?**
- ☐ **Select your primary care provider (PCP) and include the ConnectiCare provider ID number? (Can be found in the Provider Directory or on our website.)**
- ☐ **Attach a copy of your Medicare card if you are enrolled in Medicare?**
- ☐ **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?**

ConnectiCare

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English ATTENTION: If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call **800-251-7722** (TTY: **711**) or speak to your provider.

Español (Spanish) ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al **800-251-7722** (TTY: **711**) o hable con su proveedor.

Português do Brasil (Portuguese) ATENÇÃO: Se você fala português, serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para **800-251-7722** (TTY: **711**) ou fale com seu provedor.

POLSKI (Polish) UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer **800-251-7722** (TTY: **711**) lub porozmawiaj ze swoim dostawcą.

中文 (Simplified Chinese) 注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 **800-251-7722**（文本电话：**711**）或咨询您的服务提供商。

Italiano (Italian) ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l' **800-251-7722** (tty: **711**) o parla con il tuo fornitore.

Français (French) ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le **800-251-7722** (TTY: **711**) ou parlez à votre fournisseur.

Kreyòl Ayisyen (Haitian Creole) ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd aladispozisyon w gratis pou lang ou pale a. Èd ak sèvis siplemantè apwopriye pou bay enfòmasyon nan fòma aksesib yo disponib gratis tou. Rele nan **800-251-7722** (TTY: **711**) oswa pale avèk founisè w la.

РУССКИЙ (Russian) ВНИМАНИЕ: Если вы говорите на русском, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону **800-251-7722** (TTY: **711**) или обратитесь к своему поставщику услуг.

Việt (Vietnamese) LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số **800-251-7722** (Người khuyết tật: **711**) hoặc trao đổi với người cung cấp dịch vụ của bạn.

العربية (**Arabic**)

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم **800-251-7722** (**711**) أو تحدث إلى مقدم الخدمة.

한국어 (Korean)주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. **800-251-7722** (TTY: **711**) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

SHQIP (Albanian) VINI RE: Nëse flisni shqip, shërbime falas të ndihmës së gjuhës janë në dispozicion për ju. Ndihma të përshtatshme dhe shërbime shtesë për të siguruar informacion në formate të përdorshme janë gjithashtu në dispozicion falas. Telefononi **800-251-7722** (TTY: **711**) ose bisedoni me ofruesin tuaj të shërbimit.

हिंदी **(Hindi)** ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। **800-251-7722** (TTY: **711**) पर कॉल करें या अपने प्रदाता से बात करें।

Tagalog (Tagalog) PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa **800-251-7722** (TTY: **711**) o makipag-usap sa iyong provider.

Ελληνικά (Greek) ΠΡΟΣΟΧΗ: Εάν μιλάτε ελληνικά, υπάρχουν διαθέσιμες δωρεάν υπηρεσίες υποστήριξης στη συγκεκριμένη γλώσσα. Διατίθενται δωρεάν κατάλληλα βοηθήματα και υπηρεσίες για παροχή πληροφοριών σε προσβάσιμες μορφές. Καλέστε το **800-251-7722** (TTY: **711**) ή απευθυνθείτε στον πάροχό σας.

NOTICE OF NONDISCRIMINATION POLICY

Discrimination is Against the Law

ConnectiCare complies with Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes. ConnectiCare does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

ConnectiCare:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
    - Qualified sign language interpreters.
    - Written information in other formats (large print, audio, accessible electronic formats, and other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
    - Qualified interpreters.
    - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services contact the Civil Rights Coordinator by calling Member Services at **800-251-7722** (TTY: **711**).

If you believe that ConnectiCare has failed to provide these services or discriminated in another way based on race, color, national origin, age, disability, or sex, you can file a grievance with the Civil Rights Coordinator by writing to ConnectiCare Grievance and Appeals Department, P.O. Box 4061, Farmington, CT 06034-4061; faxing them at **800-319-0089**; or calling Member Services at **800-251-7722**. (Dial **711** for TTY services.) You can file a grievance in person, by mail, by fax, or through your secure member portal. If you need help filing a grievance, ConnectiCare's Grievance and Appeals Department is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **ocrportal.hhs.gov/ocr/portal/lobby.jsf** or by mail or phone at: **U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201**; **800-368-1019** (TTY: **800-537-7697**).

Complaint forms are available at **hhs.gov/ocr/office/file/index.html**.

This notice is available on ConnectiCare's website at **connecticare.com/legal/nondiscrimination**.