ConnectiCare, Inc. & Affiliates
175 Scott Swamp Road
P.O. Box 4058
Farmington, CT 06034-9863

connecticare.com

Member Information Update Form (Tax Year 2019)

1. Fill out the information below for each of the individuals listed under your health plan. If you need additional space, feel free to print another blank form from our website. Please print clearly.
2. Sign and date the form and mail it back to the above address, or you can give the completed form to an associate at a ConnectiCare center. Go to visitconnecticare.com for hours and locations of our centers.

First Name	Last Name	Date of Birth (mm/dd/yyyy)	Social Security Number

I declare that the name(s) and Social Security number(s) on this form are correct (or I am waiting for a number to be issued).

Member signature:	Date (mm/dd/yyyy):