

**Subscriber: Complete the following sections, sign at bottom and read information on reverse side.**

Please check appropriate item:  New Enrollment  Terminate Enrollment  Add Dependent  Remove Dependent  Change Plan  
 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  Widowed  Divorced

**2022 Plans:**

**Hospital Copayment Plans:**  Choice Mass HMO Copay \$40  Choice Mass POS Copay \$40

**Upfront Deductible Copay or Coinsurance Plans:**

- Choice Mass HMO Copay \$2000/\$4000
- Choice Mass HMO Copay \$2000/\$4000 ded.
- Choice Mass HMO Copay \$2500/\$5000
- Choice Mass POS Copay \$3000/\$6000

**HSA Compatible Plans:**

- Choice Mass POS HSA \$2,500/\$5,000
- Choice Mass HMO HSA \$3000/\$6000
- Choice Mass POS HSA \$4,500/\$9,000
- Choice Mass POS HSA \$5,600/\$11,200

<b>Dependent(s):</b> 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
Subscriber				<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?

Subscriber  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.

Subscriber:  
 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 insurance information (REQUIRED FIELDS)**

Will this policy replace any other health insurance policy currently active?  Yes  No  
 If yes, Name of other insurance carrier \_\_\_\_\_ If ConnectiCare, provide policy number: \_\_\_\_\_

Type of coverage  
 Employer  Individual

Are you or any of your dependents enrolled in Medicare or any Medicare Advantage Program?  Yes  No  
 If yes, name of person and coverage type: \_\_\_\_\_

**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. 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.

\_\_\_\_\_  
 Subscribers's Signature Date

### **IMPORTANT: SUBSCRIBER/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 Website)**
- 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?**

### **BROKER COMMISSION DISCLOSURE:**

Premium for all individual policies includes the cost of using a licensed insurance broker to assist individuals in selecting a plan. Insurance brokers are paid a monthly fee of \$12 per application.



# Language & Non-Discrimination Notice

ConnectiCare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ConnectiCare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

ConnectiCare:

- Provides free aids and services to people with disabilities to communicate effectively with us, including qualified interpreters and information in alternate formats.
- Provides free language services to people whose primary language is not English, including translated documents and oral interpretation.

If you need these services, contact The Committee for Civil Rights.

If you believe that ConnectiCare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

The Committee for Civil Rights, ConnectiCare, 175 Scott Swamp Road, Farmington, CT 06032, Phone: 1-800-251-7722, and TTY: 711. You can file a grievance in person or by mail. If you need help filing a grievance, The Committee for Civil Rights 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 <https://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, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Continued →

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-251-7722 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-251-7722 (TTY: 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-251-7722 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-800-251-7722 (TTY: 711)。

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-251-7722 (TTY: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-251-7722 (ATS: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-251-7722 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-251-7722 (телетайп: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-251-7722 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-251-7722 (رقم هاتف الصم والبكم: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-251-7722 (TTY: 711)번으로 전화해 주십시오.

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-251-7722 (TTY: 711).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-251-7722 (TTY: 711) पर कॉल करें।

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-251-7722 (TTY: 711).

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-251-7722 (TTY: 711).

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសាដោយមិនគិតល្អល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-251-7722 (TTY: 711)។

सुचना: જો તમે ગુજરાતી બોલતા છે, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-251-7722 (TTY: 711).