ConnectiCare of Massachusetts, Inc.

ConnectiCare Small Group Administration c/o CBIA Service Corp
350 Church Street, Hartford, CT 06103-1126 • Fax: 860-278-0883

Small Group Enrollment/Change Form

Please print clearly, complete in full using ballpoint pen.

EMPLOYER: Complete this section. Form cannot be processed without this information.

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	Length of coverage: ☐ 30 months ☐ 36 months ☐ Other_____
	_____				

Employer Signature ▶	Title	Date

EMPLOYEE: 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
☐ 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 ☐ 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

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	☐	☐		☐ M ☐ F				☐ Yes ☐ No
Spouse/Civil Union/Domestic Partner	☐	☐		☐ M ☐ F				☐ Yes ☐ No
Dependent 1	☐	☐		☐ M ☐ F				☐ Yes ☐ No
Dependent 2	☐	☐		☐ M ☐ F				☐ Yes ☐ No
Dependent 3	☐	☐		☐ M ☐ F				☐ Yes ☐ 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.) ☐ 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. 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.

▶ _____
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 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?**

ConnectiCare

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៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-251-7722 (TTY: 711)។

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