ConnectiCare

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 ☐ Divorced ☐ Widowed

2023 CBI Plans:

Upfront Deductible Copay or Coinsurance Plans: ☐ Choice Bronze POS ☐ Choice Silver POS

HSA Compatible Plans: ☐ Choice Bronze POS HSA ☐ Choice Silver POS HSA

Passage Plans*: ☐ Passage Gold POS PCP

* Members must select a PCP from the Passage Network and include the PCP's name on the enrollment form. Referrals are required from your Passage PCP to see a specialist. Find participating Passage Network PCPs with the "Find a Doctor" tool on **connecticare.com**

2023 Small Group Plans:

Copay/Coinsurance Plans: ☐ FlexPOS Copay $20 with Dental

Passage Plans*: ☐ Passage HMO PCP Copay $6500/$13000 ded. ☐ Passage HMO PCP Coins. $8,500

* Members must select a PCP from the Passage Network and include the PCP's name on the enrollment form. Referrals are required from your Passage PCP to see a specialist. Find participating Passage Network PCPs with the "Find a Doctor" tool on **connecticare.com**

Upfront Deductible Copay or Coinsurance Plans:

- ☐ FlexPOS Copay/Coins. $1,500 with Dental
- ☐ FlexPOS Copay/Coins. $2,000
- ☐ FlexPOS Copay/Coins. $2,500
- ☐ FlexPOS Copay $3,500
- ☐ FlexPOS Copay/Coins $4,000
- ☐ FlexPOS Copay/Coins $4,000 with Dental
- ☐ FlexPOS Copay/Coins. $4,500 with Dental
- ☐ FlexPOS Copay/Coins. $5,300
- ☐ FlexPOS Coins. $7,500 with Dental

HSA Compatible Plans:

- ☐ FlexPOS HSA Copay/Coins. $3,500/$7,000 ded. with Dental
- ☐ FlexPOS HSA Copay/Coins. $4,000
- ☐ FlexPOS HSA Coins. $5,800/$11,600 ded. with Dental
- ☐ FlexPOS HSA Copay/Coins $6,400/$12,800 ded. with Dental

Compass Plan: ☐ Compass HMO Copay/Coins. $2,000 with Dental

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

Race/Ethnicity (Required): This information is designed for the purpose of data collection and will not be used to determine eligibility, rating, or claim payment.

Employee:
Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino **Race:** ☐ White ☐ Black/African American ☐ Asian ☐ Amer. Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Other: _____

Spouse/Civil Union/Domestic Partner:
Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino **Race:** ☐ White ☐ Black/African American ☐ Asian ☐ Amer. Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Other: _____

Dependent 1:
Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino **Race:** ☐ White ☐ Black/African American ☐ Asian ☐ Amer. Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Other: _____

Dependent 2:
Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino **Race:** ☐ White ☐ Black/African American ☐ Asian ☐ Amer. Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Other: _____

Dependent 3:
Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino **Race:** ☐ White ☐ Black/African American ☐ Asian ☐ Amer. Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Other: _____

☐ Check if enrolling a disabled dependent age 26 or over and contact CBIA Service Corp. 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. 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.

▶ 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 Insurance Company, Inc. (CICI), or a 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 carry out the plan administration purposes and that CICI 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. 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 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 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?**

DISCLOSURE OF MEDICAL LOSS RATIO

The medical loss ratio is defined as the ratio of incurred claims to earned premium for the prior calendar year for managed care plans issued in Connecticut. Claims shall be limited to medical expenses for services and supplies provided to enrollees and shall not include expenses for stop loss, reinsurance, enrollee educational programs, or other cost-containment programs or features.

The federal medical loss ratio has the same meaning as provided in and calculated in accordance with PPACA (Patient Protection and Affordable Care Act), PL 111-148, as amended from time to time, and regulations adopted thereunder.

- State Medical Loss Ratio for calendar year 2021 for ConnectiCare, Inc. (CCI): 83.4%
- Federal Medical Loss Ratio for calendar year 2021 for ConnectiCare, Inc. (CCI):

  Individual: 87.0%
  Small Group: N/A
  Large Group: 86.8%

- State Medical Loss Ratio for calendar year 2021 for ConnectiCare Insurance Company, Inc. (CICI): 90.3%
- Federal Medical Loss Ratio for calendar year 2021 for ConnectiCare Insurance Company, Inc. (CICI):

  Individual: 73.5%
  Small Group: 85.9%
  Large Group: 88.5%

The Federal medical loss ratio has the same meaning as provided in and calculated in accordance with PPACA, PL 111-148, as amended from time to time, and regulations adopted thereunder.

- State Medical Loss Ratio for calendar year 2021 for ConnectiCare Benefits, Inc. (CBI): 94.9%
- Federal Medical Loss Ratio for calendar year 2021 for ConnectiCare Benefits, Inc. (CBI): Individual 87.3%

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