cbia health connections

Enrollment/Change Form
ACA-Compliant Plans January 2023 and beyond

Small Group
50 or fewer employees

Employer Name: ______________________ **Pending Paperwork Number** __________

Contact your benefits administrator for eligibility and available options.

Employer Group Number: ______________ **Division Name:** ______________

ENROLLMENT/CHANGE REASON

❑ Enroll ❑ Change ❑ Terminate ❑ Other Reason ____________________

EMPLOYEE INFORMATION

Employee Name		Date of Hire/Rehire/Retirement	Part- to Full-time Employment Date		Effective Date
Street Address	Apt #	Email		Marital status ❑ Single ❑ Married	# of hours worked per week: ______ Are you: ❑ Actively at work ❑ COBRA ❑ Retired
City, State, ZIP		Home Telephone ( )	Work Telephone ( )		Do you or any dependents have Medicare? Part A ____ Part B ____ Both ____

LIST YOURSELF AND ALL ELIGIBLE DEPENDENTS AND INDICATE ELECTIONS AT RIGHT. (Note that dependent coverage ends at age 26.)

Name (Last Name, First Name, Middle Initial)	Gender	Birth date MM/DD/YY	Social Security #	PCP if selecting a Passage plan	CtCare Provider ID # (optional)	Medical	Dental	Vision	Critical Illness	Accident	Hospital Indemnity
Employee	❑ M ❑ F										
Spouse Includes civil unions and domestic partners	❑ M ❑ F										
Child	❑ M ❑ F										
Child	❑ M ❑ F										
Child	❑ M ❑ F										
Child	❑ M ❑ F										

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.

MEDICAL

ConnectiCare Fully Insured ACA-Compliant Plans

Benefit plans:

- ❑ Passage HMO PCP Copay $6,500/$13,000 ded.*
- ❑ Compass HMO Copay/Coins. $2,000 with Dental
- ❑ Passage HMO PCP Coins. $8,500*
- ❑ FlexPOS Copay $20 with Dental
- ❑ 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
- ❑ FlexPOS Coins. $7,500 with Dental
- ❑ FlexPOS Copay/Coins. $4,000
- ❑ FlexPOS Copay/Coins. $4,500 with Dental
- ❑ FlexPOS Copay/Coins. $5,300
- ❑ FlexPOS Copay/Coins. $4,000 with Dental
- ❑ FlexPOS Copay/Coins. $1,500 with Dental
- ❑ FlexPOS Copay/Coins. $2,000
- ❑ FlexPOS Copay/Coins. $2,500
- ❑ FlexPOS Copay $3,500
- ❑ Choice Bronze POS HSA[1]
- ❑ Choice Silver POS HSA[1]
- ❑ Choice Bronze POS[1]
- ❑ Choice Silver POS[1]
- ❑ Passage Gold POS PCP[1]

HSA and HRA Integration

Must be offered by your employer

- ❑ HSA integration
- ❑ HRA integration

* Selection of a PCP from the Passage network is required. Find participating Passage network PCPs with the Find a Doctor tool on connecticare.com. Write your PCP selection in the space provided above.

[1] This ConnectiCare plan is underwritten by ConnectiCare Benefits, Inc. (CBI), and is not part of the CBIA Service Corporation (CBIASC) policy. It uses a different network and drug formulary.

Waive Medical (indicate reason)

- ❑ Other group coverage
- ❑ Medicare coverage
- ❑ Medicaid coverage
- ❑ Military coverage
- ❑ Individual coverage through state exchange
- ❑ No other coverage

Medicare (Additional forms are required for each employee & dependent) ❑ Anthem Medicare Supplement ConnectiCare Medicare Advantage: ❑ High ❑ Low

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Employee Name: ______________________

Employer Group Number: ______________

LIFE & DISABILITY

Group Basic Life

❑ Life

Amount $__________

If life amount is salary-based, enter your annual salary $__________

STD/LTD

❑ Elect STD ❑ Waive STD

❑ Elect LTD* ❑ Waive LTD

Annual salary $__________

* Not available to employees who work fewer than 30 hours per week

Voluntary Life (for groups with 10 or more eligible employees)

Employee

❑ Elect $__________ OR______ x salary

If life amount is salary-based, enter your annual salary $__________

Amounts over $100,000 require a Personal Health Application.

❑ Waive

Dependent

❑ Spouse - Amount $__________ (Amounts over $50,000 require a Personal Health Application.)

❑ Child(ren)

❑ Both

❑ Waive

Supplemental Life
(for groups with 3 to 9 eligible employees)

❑ Elect ❑ Waive

If electing Supplemental Life, complete a separate Supplemental Life Enrollment Form.

Beneficiary

This is the only record of your beneficiary designation. Please retain a copy and give a copy to your employer to submit at the time of request for death benefits.

Beneficiary Name (Last, First, MI) ______________________

Relationship of Beneficiary ______________________ Date __________

DENTAL (List all dependents you are enrolling on page 1)

Voluntary - Ameritas

❑ Passive PPO 100%/80%/0%–$750

❑ Passive PPO 100%/50%/50%–$750

❑ Active PPO 100%/80%/50%–$1,000

❑ Passive PPO 100%/80%/50%–$1,000

❑ Passive PPO 100%/80%/50%–$1,500 with ortho

❑ Waive

Group - Ameritas

❑ Active PPO 100%/100%/60% $700

❑ Passive PPO 100%/80%/50% $1,250

❑ Passive PPO 100%/80%/50% $1,250 w/ Ortho

❑ Passive PPO 100%/80%/0% $1,000

❑ Passive PPO 100%/80%/50% $1,000

❑ Passive PPO 100%/80%/50% $1,000 w/ Ortho

❑ Passive PPO 100%/80%/50% $1,500

❑ Passive PPO 100%/80%/50% $1,500 w/ Ortho

❑ Passive PPO 100%/80%/50% $2,000

❑ Passive PPO 100%/80%/50% $2,000 w/ Ortho

❑ Waive

VOLUNTARY ACCIDENT & ILLNESS BENEFITS. (Note that dependent coverage ends at age 26.)

Critical Illness Insurance

❑ Plan A ❑ Plan B ❑ Waive

Accident Insurance

❑ Plan A ❑ Plan B ❑ Waive

Beneficiary______________________

Relationship______________ Date__________

Hospital Indemnity Insurance

❑ Plan A ❑ Plan B ❑ Waive

VISION

❑ Elect ❑ Waive

IDENTITY THEFT

❑ Elect (employee email address required above) ❑ Waive

☐ Individual ☐ Gold

☐ Family ☐ Platinum

AUTHORIZATION AND ACCEPTANCE

I hereby apply for the health plan and benefit plan selected, understanding all benefits and coverage as specified in the enrollment brochure and agreeing to abide by all the rules and regulations therein specified. I authorize deductions from my earnings of the required contributions, if any, toward the cost of the coverage. The information provided is true and correct to the best of my knowledge. I understand my coverage and benefits may be affected by failure to provide complete and accurate information.

Important: The employee's and employer's signatures are required before submitting this application. CBIA Service Corp. reserves the right to deny or delay enrollment if information or required signatures are missing from this enrollment form.

If you're declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, civil union, domestic partner, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided you request enrollment within 30 days after the qualifying event.

Employee Signature ______________________ Date __________

Employer Signature ______________________ Date __________

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Employee Name: ______________________________

Employer Group Number: ____________________

Connecticut Public Act 09-46

Insurance Company Medical Loss Ratios for 2021

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 and shall otherwise be calculated in accordance with the requirements of Connecticut state law. For calendar year 2021, medical loss ratios for insurance companies that participate in CBIA Health Connections are:

ConnectiCare Insurance Company Inc.*	90.3%
ConnectiCare Insurance Company Inc.**	85.9%

* 2021 State Medical Loss Ratio
** Small Group 2021 Federal Medical Loss Ratio

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