cbia health connections

COBRA/State Continuation Enrollment/Change Form

ACA-Compliant Plans January 2023 and beyond

Small Group
50 or fewer employees

Contact your benefits administrator for eligibility and available options.

Employer Name: _____ **Pending Paperwork Number** _____

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
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

CONTINUED ON PAGE 2

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Employee Name: _____

Employer Group Number: _____

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

VISION

❑ Elect ❑ Waive

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

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