cbia health connections

For companies with 5 to 50 employees

Contact your benefits administrator for eligibility and available options.

COBRA/State Continuation Enrollment/Change Form

Fixed Funding Solutions January 2023 and beyond

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 #	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 Fixed Funding Solutions

Benefit plans:

❑ FlexPOS HSA $6,800/40%

❑ FlexPOS HSA $5,000/50%

❑ FlexPOS HSA $3,000/25%

❑ FlexPOS $35/$50–$4,000/35%

❑ FlexPOS $30/$50–$3,500/20%

❑ FlexPOS $30/$50–$2,000

❑ FlexPOS $30/$45–$500

HSA and HRA Integration

Must be offered by your employer

❑ HSA integration

❑ HRA integration

Waive Medical (indicate reason)

❑ Other group coverage

❑ Military coverage

❑ Medicare coverage

❑ Medicaid 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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For companies with 51 or more employees

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