cbia health connections

For companies with 51 or more employees

Contact your benefits administrator for eligibility and available options.

Enrollment/Change Form Fixed Funding Solutions January 2024 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	# 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 #	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								

*A Domestic Partner Affidavit (if applicable) must be completed at the time of enrollment and retained by the employee. A copy must be provided to the employer. See cbia.com for a copy of the affidavit.

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 $5,000 20%
❑ FlexPOS HSA $6,000 10%
❑ FlexPOS HSA $4,000 20%
❑ FlexPOS $5,000 20%
❑ FlexPOS HSA $3,200 25%
❑ FlexPOS HSA $5,000
❑ FlexPOS $30 $2,500 50%
❑ FlexPOS $30 $2,500 20%
❑ FlexPOS HSA $2,500
❑ FlexPOS HSA $1,600
❑ FlexPOS HSA $2,000 10%
❑ FlexPOS $35/$50 $4,000 20%
❑ FlexPOS $30/$50 $3,500 20%
❑ FlexPOS $30/$45 $5,000
❑ FlexPOS $30/$50 $2,000
❑ FlexPOS $30/$45 $1,500
❑ FlexPOS $30/$45

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

cbia health connections

For companies with 51 or more employees

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

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

Beneficiary_____

Relationship_____ Date_____

Accident Insurance

❑ Plan A ❑ Plan B ❑ Waive

Beneficiary_____

Relationship_____ Date_____

Hospital Indemnity Insurance

❑ Plan A ❑ Plan B ❑ Waive

Beneficiary_____

Relationship_____ Date_____

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