

Connecticut Partnership Plan

Add / Term / Change Form

Anthem Group Number:
 Cigna Branch Code:

**For HR Use Only*

New Enrollee(s):
 Term Subscriber:
 Term Dependent(s):
 Change Information:

**For HR Use Only*

EMPLOYER NAME:

EMPLOYEE NAME:
 (Last, First)

EMPLOYEE STREET ADDRESS:

CITY, STATE & ZIP:

EMPLOYEE PHONE NUMBER & EMAIL:

**Note: Phone number is vitally important. Without a valid phone number, we are unable to contact members regarding clinical programs or HEP programs.*

EFFECTIVE DATE:

COVERAGE ELECTIONS:	<u>Medical/RX</u>	<u>Dental</u>	<u>VISION</u>
Employee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Employee + 1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Waiver	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
COBRA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	NAME Last, First	Date of Birth	Social Security Number	Gender	Add / Term
EMPLOYEE					Add / Term
DEPENDENT (Spouse)					Add / Term
DEPENDENT (Child)					Add / Term
DEPENDENT (Child)					Add / Term
DEPENDENT (Child)					Add / Term
DEPENDENT (Child)					Add / Term
DEPENDENT (Child)					Add / Term
DEPENDENT (Child)					Add / Term

MEDICARE INFORMATION
 Member Name: _____
 Medicare ID Number: _____
 Part A Effective Date: _____
 Part B Effective Date: _____

EMPLOYMENT INFORMATION:
 • Employment Status: _____
 (Example: FT, PT, Disabled, Retired)
 • Number of Hours worked per week: _____
 • Hire Date: _____

EMPLOYEE SIGNATURE: _____ DATE: _____

By signing this CT Partnership Plan enrollment form, I agree, on behalf of myself and all enrolled dependents, to participate in the Health Enhancement Program (HEP). I understand that I will lose the financial incentives of the HEP program if I or any of my enrolled dependents fails to comply with the requirements of the HEP program.

