only for new employee or adds

aetna®

Aetna AFA Medical and Stop Loss Employee Enrollment/Change Form

Instructions: You must complete this enrollment form in full. If you do not, we will return it to you, and that can delay its processing. You alone are responsible for its accuracy and completeness. **If waiving coverage, please complete sections A and B.**

Employer name	Effective date	Date of hire	Member ID number (if available)

☐ New hire ☐ Rehire / reinstatement ☐ New group enrollment ☐ Late enrollment ☐ Waiver ☐ Open enrollment ☐ Other _____	☐ Change of coverage ☐ Add spouse / civil union / domestic partner ☐ Add dependent child ☐ Name change ☐ Other _____	☐ Employee termination ☐ Remove spouse / civil union / domestic partner ☐ Remove dependent child ☐ Cancel coverage	☐ **COBRA for:** ☐ Employee ☐ Dependent Length of continuation: ☐ 18 ☐ 36 ☐ Other _____ Original qualifying event date _____ Qualifying event _____ Reason _____

A. Employee information

Social Security number	Last name, first name, middle initial	Contact telephone (if we may contact you by telephone) ( ) -	Work ZIP code	Work email address (if we may correspond with you via email)

Home address	Apt. Number	City, state	Home ZIP code
Mailing address (if different from home address)	**Apt. Number**	**City, state**	**Mailing ZIP code**

Number of hours worked a week _____ **Check one:** ☐ Full time ☐ 1099 ☐ Seasonal ☐ COBRA ☐ Part time ☐ Retired ☐ Temporary ☐ Union

Employee acknowledgement: I understand that it is fraud to file an application for coverage, an enrollment form or claim that contains materially false information knowingly and with intent to defraud. It is illegal to conceal, for the purpose of misleading, information concerning any material fact. A person who commits fraud or intentionally misrepresents material facts is subject to civil penalties and may be charged with a crime. If you commit fraud or intentionally misrepresent material facts, your coverage can be cancelled or your rates can be increased back to your effective date.

I certify that all information and statements on this enrollment form are true and complete to the best of my knowledge. I have authority to make statements on behalf of any dependents listed on this form. *If I become aware of any new information after I have completed this enrollment form but before the effective date that would change any answer on this form or make me report something not reported on this form, I agree to provide that information to Aetna as soon as possible.*

Conditions of enrollment: I understand and agree that my employer's application will determine coverage and that there is no coverage unless and until Aetna approves both this enrollment form and the employer application. I agree that my employer or its agent may send this enrollment form to Aetna. I authorize all my doctors, pharmacies, hospitals and other health care providers ("providers") to give Aetna any and all personal health information about me and others listed on this form. This authorization covers all health matters including those involving mental health, substance abuse and HIV / AIDS. I further authorize Aetna to use such information and to disclose such information to affiliates, providers, payors, other insurers, third party administrators, vendors, consultants and governmental authorities with jurisdiction when necessary for my care or treatment, payment for services, the operation of my health plan, or to conduct related activities. I have discussed the terms of this authorization with my spouse and competent adult dependents and I have obtained their consent to those terms. This authorization will remain valid for the term of the coverage and so long thereafter as allowed by law. I understand that I am entitled to receive a copy of this authorization upon request and that a photocopy is as valid as the original.

Please sign here ONLY if you are enrolling in coverage for yourself and / or dependents.

X Employee signature _____ **Date** *(Month/Day/Year)* _____

B. Decline / waive – *To be completed if medical coverage is declined or refused by an eligible employee and / or their eligible family members.*

I acknowledge I have been given the right to apply for this coverage; however, I am electing not to enroll. By declining this group coverage I acknowledge that I and / or my dependents may have to wait until the plan's next anniversary date to be enrolled for group coverage. I and / or my dependents have made this decision of my / their own accord with no pressure from my employer, my employer's agent or the insurance carrier.

Medical coverage declined for:	***Please sign here ONLY if you are declining coverage for yourself and / or dependents.***
☐ Myself ☐ Spouse / civil union / domestic partner ☐ Children	**X Employee signature** _____ **Date** *(Month/Day/Year)* _____

C. Medical coverage selection

Plan Option _____

D. Other medical coverage – *List any individuals who will have other health insurance at the same time as this coverage.*

Name of individual	Carrier Name	Name of individual	Carrier Name

E. Medicare coverage – *List individuals covered by Medicare.*

Name of individual	Medicare Part A	Medicare Part B	Medicare Part D	Over Age 65	Disability	End-Stage Renal Disease Effective Date
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	

F. Individuals enrolling – List individuals enrolling or adding, changing or removing coverage. If more space is needed check here ☐ and use a separate sheet of paper.

(A)dd (C)hange (R)emove	Last name, first name, middle initial	Sex (M/F)	Social Security number	Birthdate (MM/DD/YYYY)	Height	Weight	Tobacco or nicotine use (including E-cigarette devices)	Dependent information (List city, state and ZIP code for any dependent living at another address
	☐ Employee 1.						☐ Yes ☐ No	NA
	☐ Spouse ☐ Civil union ☐ Domestic partner 2.						☐ Yes ☐ No	
	☐ Child ☐ Stepchild ☐ Other 3.						☐ Yes ☐ No	
	☐ Child ☐ Stepchild ☐ Other 4.						☐ Yes ☐ No	
	☐ Child ☐ Stepchild ☐ Other 5.						☐ Yes ☐ No	

G. Health Questionnaire – Complete for all individuals enrolling for coverage.

Have you or anyone applying for coverage consulted with or been examined, diagnosed, or treated by any health care professionals during the last five (5) years for any illness, injury or health condition in any of the categories listed below? If "yes," please check the box that most appropriately describes the condition(s) and explain fully below (page 4).

1. Cancer / tumor / cyst ☐ **Yes** ☐ **No**

☐ Brain ☐ Breast ☐ Esophagus ☐ Stomach ☐ Colon ☐ Leukemia ☐ Lymphoma ☐ Multiple myeloma ☐ Kidney ☐ Liver ☐ Lung ☐ Melanoma ☐ Pancreas ☐ Prostate
☐ Testicular ☐ Cervical ☐ Ovarian ☐ Uterine ☐ Throat ☐ Thyroid ☐ Other cancer (type / location _____) ☐ Non-malignant tumor (type / location _____)

Diagnosis date _____ **Cancer stage (0-4)** _____ **(if known) Cancer category (In situ, localized, regional, distant)** _____ **(if known)**

Treatment: ☐ **Surgery date** _____ ☐ **Chemo timeframe** _____ ☐ **Radiation timeframe** _____

☐ **Remission** ☐ Yes ☐ No **If yes, provide date of remission** _____

Continued on next page

G. Health Questionnaire *(continued)*

2. Heart / vascular ☐ Yes ☐ No

☐ Aneurysm (location _____) ☐ Blocked arteries (e.g., carotid, heart, abdomen, legs) ☐ Heart attack ☐ Heart valve disorder ☐ Congestive heart failure ☐ Cardiomyopathy
☐ Irregular or abnormal heart rhythm ☐ Stroke ☐ Vasculitis (type _____) ☐ Bypass / angioplasty / stent (location _____) ☐ Pacemaker or cardiac defibrillator
☐ Other (specify details below)

3. Blood / clotting disorder ☐ Yes ☐ No

☐ Hemophilia (specify type below) ☐ Anemia (specify type below; e.g., sickle cell, hemolytic, aplastic) ☐ Blood clots ☐ Other (specify details below)

4. Reproductive / Gynecological ☐ Yes ☐ No

☐ Current pregnancy: specify if it's a spouse, dependent child or other expectant parent even if not listed on the application (due date _____, if multiples # ___, any complications _____)
☐ Intending to adopt ☐ Infertility ☐ Other Gynecological conditions (specify details below)

5. Gastrointestinal / endocrine ☐ Yes ☐ No

☐ Diabetes ☐ Crohn's / ulcerative colitis ☐ Autoimmune hepatitis ☐ Hepatitis B (specify below if acute or chronic) ☐ Hepatitis C (if cured, when did treatment end? _____) ☐ Cirrhosis
☐ Pancreatitis ☐ Growth disorder ☐ Adrenal, pituitary, thyroid gland disorder (specify type below) ☐ Other disorders of the gallbladder, stomach, pancreas, liver, colon (specify type below)

6. Brain / neurological ☐ Yes ☐ No

☐ Amyotrophic lateral sclerosis ☐ Cerebral palsy ☐ Neuropathy / polyneuropathy ☐ Multiple sclerosis ☐ Myasthenia gravis ☐ Muscular dystrophy ☐ Brain and / or spinal cord disorder or injury
☐ Paralysis, quadriplegia, paraplegia ☐ Other (specify details below)

7. Immune / dermatology ☐ Yes ☐ No

☐ HIV or AIDS ☐ Immunodeficiency disorder ☐ Connective tissue disorder (specify type below; e.g., lupus, scleroderma) ☐ Hereditary angioedema
☐ Skin disorder (specify type below; e.g., psoriasis, eczema, ulcers, infections) ☐ Other (specify details below)

8. Lung / respiratory ☐ Yes ☐ No

☐ Cystic fibrosis ☐ COPD, chronic bronchitis, emphysema ☐ Pulmonary hypertension ☐ Pulmonary fibrosis ☐ Other (specify type below; e.g., asthma, sarcoidosis, etc.)

9. Urinary / kidney ☐ Yes ☐ No

☐ Kidney disease / disorder (specify type below) ☐ Kidney failure ☐ Dialysis: date started _____ ☐ Dialysis possible within the next 18 months ☐ Bladder disorder
☐ Prostate disorder ☐ Other (specify details below)

10. Musculoskeletal ☐ Yes ☐ No

☐ Rheumatoid or psoriatic arthritis (specify type below) ☐ Disorder of the back / neck / spine ☐ Disorder of the joints (specify location; e.g., hips, knees, shoulders) ☐ Chronic pain disorder
☐ Osteomyelitis ☐ Amputation ☐ Other (specify details below)

11. Mental health / substance abuse ☐ Yes ☐ No

☐ Alcohol and / or drug abuse (specify type below) ☐ Eating disorder ☐ Anxiety / depression ☐ Bipolar disorder ☐ Schizophrenia ☐ Suicide attempt ☐ Oppositional defiant / conduct disorder
☐ Autism ☐ ABA therapy ☐ Other (specify details below)

12. Transplant ☐ Yes ☐ No

☐ Organ or bone marrow / stem cell transplant already performed (date _____) ☐ Future transplant planned / scheduled (date _____)
☐ Transplant discussed / recommended / possible within the next 18 months ☐ Transplant complications ☐ Other (specify details below)

Continued on next page

G. Health Questionnaire *(continued)*

13. Birth / inherited conditions ☐ **Yes** ☐ **No**

☐ Premature birth (gestational age: ___ # weeks) ☐ Congenital birth defect ☐ Genetic / metabolic disorder ☐ Any syndrome (specify details below) ☐ Other (specify details below)

14. Eyes / ears / nose / throat ☐ **Yes** ☐ **No**

☐ Acoustic neuroma ☐ Cataracts ☐ Cleft lip / palate ☐ Deviated septum ☐ Glaucoma ☐ Retinopathy ☐ Chronic ear infections ☐ Chronic sinusitis ☐ Other (specify details below)

15. Medications ☐ **Yes** ☐ **No**

Current medications:

Person _____ # of meds ____ Person _____ # of meds ____ (list medication name(s) and diagnosis below)

Medications taken within the past 12 months:

Person _____ # of meds ____ Person _____ # of meds ____ (list medication name(s) and diagnosis below)

16. Incapacitated ☐ **Yes** ☐ **No**

Reason: ☐ Disabled ☐ Handicapped ☐ Congenital disorder ☐ Other (specify details below)

17. Other ☐ **Yes** ☐ **No** (specify details below)

☐ Hospitalizations in the past 5 years ☐ Future surgeries or hospitalizations discussed / planned / recommended / scheduled or possible within the next 18 months

☐ Other conditions not addressed elsewhere in the application

Provide details below for all "yes" answers indicated above. If additional space is needed, attach a separate sheet. All attachments must be signed and dated by the applicant.

Ques. No.	Enrollee name	Conditions / diagnosis	Date diagnosed	Treatment (include surgery, hospitalized, durable medical equipment / supplies, etc.)	Medication names (include those taken orally, injected, infused, topically, nasally, inhaled, etc.)	Dates treated	Is treatment ongoing? If **yes**, provide details of any current OR future treatment.

vision only

cbia health connections

Enrollment/Change Form ACA-Compliant Plans May - Dec. 2020

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										

MEDICAL

ConnectiCare Fully-Insured ACA-Compliant Plans

- ❑ FlexPOS $7,300/50%
- ❑ FlexPOS HSA $40/$50-$6,350/10%
- ❑ FlexPOS HSA $40/$60-$5,000/50%
- ❑ FlexPOS HSA $40/$50-$3,500/25%
- ❑ FlexPOS HSA $40/$50-$3,000/20%
- ❑ FlexPOS $50/$60-$4,250/40%
- ❑ FlexPOS $45/$50-$3,500/40%
- ❑ FlexPOS $45/$60-$3,000/30%
- ❑ FlexPOS $40/$50-$3,000
- ❑ FlexPOS $40/$50-$2,500/20%
- ❑ FlexPOS $40/$50-$2,000
- ❑ FlexPOS $40/$50
- ❑ Passage HMO $30/$50-$2,500/25%*
- ❑ Passage HMO $30/$50-$6,000*

*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.

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

LIFE & DISABILITY

Group Basic Life

❑ Life (Required)

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 _____

VISION

❑ Elect ❑ Waive

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 - Aetna

- ❑ DMO 100%/100%/60%*; Dental PCD # _____
- ❑ PPO Max 100%/80%/50%–$1,250
- ❑ Passive PPO 100%/80%/50%–$1,000
- ❑ Passive PPO 100%/80%/50%–$1,500*
- ❑ Passive PPO 100%/80%/50%–$2,000
- ❑ Waive

* Not available to companies with fewer than 10 eligible employees

- ❑ Dental DMO; Dental PCD # _____
- ❑ Standard PPO
- ❑ Enhanced PPO
- ❑ Passive PPO 1000
- ❑ Existing employer plan

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

Beneficiary_____

Relationship_____ Date_____

❑ Waive

Hospital Indemnity Insurance

❑ Plan A ❑ Plan B

❑ 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

Connecticut Public Act 09-46

Insurance Company Medical Loss Ratios for 2018

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 2018, medical loss ratios for insurance companies that participate in CBIA Health Connections are:

ConnectiCare Insurance Company Inc.*	80.3%
ConnectiCare Insurance Company Inc.**	86.8%

* 2018 State Medical Loss Ratio

** Small Group 2018 Federal Medical Loss Ratio