Connecticut Partnership Plan 2.0

Enrollment Form for New Enrollee

New Enrollee: ☐
Anthem Group Number: ☐
Cigna Branch Code: ☐
*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:	Medical/RX	Dental	Vision
Employee	☐	☐	☐
Employee + 1	☐	☐	☐
Family	☐	☐	☐
Waiver	☐	☐	☐
COBRA	☐	☐	☐

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

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.

OFFICE of the STATE COMPTROLLER