Connecticut Partnership Plan 2.0

Enrollment Form for New Enrollee

New Enrollee: ■

Anthem Group Number: L00125

Cigna Branch Code: 61227

**For HR Use only*

EMPLOYER NAME: East Windsor Public Schools

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/Vision	Dental A	Dental ABCD Buy-Up
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.

Anthem

OFFICE *of the* STATE COMPTROLLER