Anthem BlueCross BlueShield

Connecticut Partnership Plan 2.0
Enrollment and Membership Change Form

CONNECTICUT PARTNERSHIP PLAN 2.0

1. Tell Us About You

S.S.N.

Last Name | First Name | M.I.

Home Address: Number & Street or P.O. Box

City | State | Zip Code

Home/Cell: | Email:

Marital Status
☐ Single ☐ Legally Separated ☐ Widowed
☐ Married ☐ Separated ☐ Divorced

2. New Membership

☐ New Hire
☐ Open Enrollment
☐ COBRA/C.G.S. 38a-538

Date of Qualifying Event
____/____/____

☐ New Group (Orig. Enroll.)

3. Change Membership

Change:
☐ Address
☐ Name
☐ Other
Date

To Be Completed By Employer

Requested Effective Date
____/____/____

Firm Division No.

Health Benefit Plan

Anthem CSP Code:

4. Your Membership Choices

Medical Insurance ☐ Self ☐ Two-Person ☐ Family

5. Where You Work

Name of Plainville Community School (If Applicable):

Do you currently work 30 or more hours per week? ☐ Yes ☐ No

Date of Full Time Hire | Date of Part Time Hire | Date of Rehire

6. List Members To Be Added/Cancelled

Sex	Name (First/Middle/Last)	Add	Cancel	Social Security Number	Date of Birth (MM/DD/YYYY)
☐ M ☐ F	Self				
☐ M ☐ F	Spouse				

DEPENDENTS: Children over 19 may be eligible if disabled, or unmarried full-time students. Please circle disabled dependent.

☐ M ☐ F					
☐ M ☐ F					
☐ M ☐ F					
☐ M ☐ F					

7. Tell Us About Your Other Insurance

Do you or any other member of your family have any other medical, dental, or Anthemcoverage? ☐ Yes ☐ No
If yes, please fill in the information below. ☐ Self ☐ Spouse ☐ Children

Name of Other Insurance Company	Name of Policyholder	Policy or ID No.	Reason for Termination	First/Last Date of Coverage

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.

8. Employee Signature

Date