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

Reason for change:
New Hire _____
Marriage _____
Divorce _____
Birth or Adoption_____
Loss of Coverage _____
Other _____

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 / Delete
EMPLOYEE					Add / Del
DEPENDENT (Spouse)					Add / Del
DEPENDENT (Child)					Add / Del
DEPENDENT (Child)					Add / Del
DEPENDENT (Child)					Add / Del
DEPENDENT (Child)					Add / Del
DEPENDENT (Child)					Add / Del
DEPENDENT (Child)					Add / Del

Return the completed and signed form to Christine Morris via FAX 860-464-8589, US mail - 4 Blonders Blvd, Ledyard CT 06339 or interoffice mail.

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