Connecticut Partnership Plan
Add / Term / Change Form

Anthem Group Number:	
*For HR Use Only	

New Enrollee(s):	
Term Subscriber:	
Term Dependent(s):	
Change Information:	
*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
Employee Only	
Employee + 1	
Family	
Waiver	
COBRA	

	NAME Last, First	DOB	Social Security Number	Gender	Add / Term
EMPLOYEE					Add / Term
DEPENDENT (Spouse)					Add / Term
DEPENDENT (Child)					Add / Term
DEPENDENT (Child)					Add / Term
DEPENDENT (Child)					Add / Term
DEPENDENT (Child)					Add / Term
DEPENDENT (Child)					Add / Term
DEPENDENT (Child)					Add / Term

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.