

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.