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

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	Dental	VISION
Employee	☐	☐	☐
Employee + 1	☐	☐	☐
Family	☐	☐	☐
Waiver	☐	☐	☐
COBRA	☐	☐	☐

	NAME Last, First	Date of Birth	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.

Anthem

OFFICE *of the* STATE COMPTROLLER